

CSAP Monograph

Drug-Free Communities by the Year 2000

CSAP Prevention
Monograph-14

Experiences With
Community Action Projects:

*New Research in the
Prevention of Alcohol
and Other Drug Problems*



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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CSAP Prevention Monograph-14

EXPERIENCES WITH COMMUNITY ACTION PROJECTS: NEW RESEARCH IN THE PREVENTION OF ALCOHOL AND OTHER DRUG PROBLEMS

Editors:

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Rockville, MD 20857**

CSAP Prevention Monographs are prepared by the divisions of the Center for Substance Abuse Prevention (CSAP) and published by its Division of Communication Programs. The primary objective of this series is to facilitate the transfer of prevention and intervention technology between and among researchers, administrators, policymakers, educators, and providers in the public sectors. The content of state-of-the-art conferences, reviews of innovative or exemplary programming models, and reviews of evaluative studies are important elements of CSAP's information dissemination mission.

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CSAP Production Officer: Joan Quinlan
Library of Congress Catalog Card Number: 92-085284
DHHS Publication No. (ADM)93-1976
Printed 1993

CSAP Prevention Monograph Series

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As of October 1, 1992, ADAMHA was reorganized. The Office for Substance Abuse Prevention (OSAP) became the Center for Substance Abuse Prevention (CSAP) and the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) became the Substance Abuse and Mental Health Services Administration (SAMHSA). This document was written before the changes took effect; to avoid confusion and allow a time for transition, the former names and acronyms have been retained.

Foreword

"Experiences With Community Action Projects: New Research in the Prevention of Alcohol and Other Drug Problems" describes the results of the second international research symposium, which was held from January 29 to February 2, 1992, in San Diego, California. This conference of international researchers grew out of a symposium in Scarborough, Ontario, in March 1989. The second symposium was seen by planners as building on the first one by focusing on how to improve the collaboration of researchers and community activists.

Papers in these proceedings examine newly evaluated community projects begun after the first symposium. These include projects from the community prevention grants of the Center for Substance Abuse Prevention (CSAP), the community trials grant program funded by CSAP and the National Institute on Alcohol Abuse and Alcoholism, and the Robert Wood Johnson Foundation community partnership grant projects. These reports consider the pros and cons of research-driven versus program-driven alcohol and other drugs (AOD) prevention programs and the process of project design involving both.

Articles in this volume examine new evaluations of intercommunity differences that affect the impact of specific alcohol control measures and how to assess these and other prevention measures in natural experiments. The second section reports experiences with case studies from licensed drinking establishments and antidrinking campaigns from Canada and Australia. In addition, it covers two Canadian studies involving the program philosophy and politics of drunk driving prevention and tobacco regulations. This volume also covers the promotion of alcohol in the United States during the 1991 college spring break.

We hope that the knowledge shared in this volume will stimulate and direct worldwide alcohol and other drug prevention programs and suggest pathways for similar international partnerships for the future.

*Vivian L. Smith, MSW
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Preface

This monograph is the result of the second international research symposium on "Experiences with Community Action Projects for the Prevention of Alcohol and Other Drug Problems," which was held from January 29 to February 2, 1992, in San Diego, California. This conference of international researchers grew out of a symposium of the same title, which took place in Scarborough, Ontario, nearly 3 years before, in March 1989. The book therefore includes preliminary findings from a number of studies that were designed and started following the first conference. As with the earlier monograph that emerged from the first symposium, OSAP Prevention Monograph No. 4, authors were encouraged to modify their papers based on discussions that took place and workshops that were embedded in the symposium (see Chapter 7). New material based on participants' comments and plenary sessions was also developed. Like its predecessor, this monograph is, therefore, more than a typical conference proceedings document.

The first symposium represented a benchmark signifying the "coming of age" of community-focused research and action within the field of alcohol and other drug problem prevention. There was a clear enthusiasm for moving beyond individually focused change efforts toward concerted action on the community level. But there was at that time an uneasiness with the state of the art in research approaches suited to studying grassroots and other large-scale change processes. As stated in the preface to OSAP Monograph No. 4, organizers of the 1989 symposium were guided by a strong reality principle and a commitment to "truth saying," and "explicitly encouraged participants to take a reflective, confessional stance" to discuss openly the frustrations and obstacles encountered by researchers in this area. Brought so to light, it was hoped that problems could be better identified and addressed in planning and implementing future projects. The reader of this monograph must judge the degree to which incremental progress has been made since the first symposium 3 years ago in conceptualizing suitable research designs, developing appropriate methodology, implementing community research-action projects, and disseminating generalizable findings. Suffice to say that the organizers of the second international symposium noted in the call for abstracts that the 1989 symposium, while providing valuable insight on the question of "what works," also "raised a number of vexing, and interesting, issues on the design and implementation of evaluation projects in relation to community action initiatives." The

second symposium was aimed at providing "a forum for expanding discussions initiated in 1989, with the objective of further illuminating the evaluation process."

The sustained interest in community-based approaches to prevention was evidenced by the number of researchers who are working in and with communities, seeking ways of harnessing the power of local people and organizations acting in concert to address problems with alcohol and other drugs that they experience directly. Many prevention researchers and quite a few prevention practitioners expressed interest in attending the second symposium. Many who ultimately submitted papers in response to a widely circulated call for abstracts had been at the first conference, but there were many who attended who had not been at the first meeting. A number of international researchers and government officials contemplating new studies involving communities attended as observers, and several experienced individuals were asked to provide reflective responses to each day's proceedings.

Community-based prevention is an inherently difficult area in which to conduct effective research; the dilemmas and complexities continually faced call for unusual qualities in those engaged in serious study of process and outcomes that goes beyond mere program description and documentation. Judging by the number of ambitious studies under way, the importance of addressing "messy" problems in real-world conditions outweighs the difficulty and frustrations invariably encountered. The challenge of working with whole communities engages numerous prevention researchers who appreciate that many alcohol and other drug problems must be "taken on" at the environmental level with intimate involvement of community members at many levels if change is to take root and be sustained. In fact, the conditions for instigating and sustaining community change were a continued concern reflected in papers and discussions at both symposia.

The second symposium was seen by its planners as building on the 1989 session by (1) focusing on how to improve collaboration of researchers and community activists with an intent to explore how to meld agendas of both; (2) examining new before-after evaluated community projects initiated since the first symposium such as the community prevention grants of the U.S. Office for Substance Abuse Prevention and the community trials grant program of the U.S. National Institute on Alcohol Abuse and Alcoholism, and the Robert Wood Johnson (RWJ) Foundation community partnership grant projects, and revisiting projects included in the first symposium that have since had an opportunity to mature; (3) considering the pros and cons of research-driven versus program-driven prevention campaigns and the process of program design involving both aspects; (4)

examining inter-community differences that may affect the impact of specific alcohol control measures and how to assess these and other prevention measures in "natural experiments," and expanding methodologies for generating and evaluating community involvement in prevention projects and studying levels of community readiness for action projects; (5) widening participation of those who are not necessarily researchers but who can contribute their experience of community action so as to extend our conceptualizations; and (6) transferring wherever possible research and theory from fields other than the AOD area.

In addition to empirical studies based on longitudinal evaluations measuring change, conceptual and methodological papers addressing some of the important themes arising out of the first symposium were invited. In brief, themes that could be addressed included program and research design, sequencing and coordinating intervention elements, community typologies useful for prevention, community assessment, community organization including how communities develop ownership and sustain projects, the role of communities in shaping public policies, community ecology, strategies for special populations, planning processes, and needs assessment methods to stimulate community action.

Papers in this monograph follow the format of the conference, and are organized under a number of broad headings. First, conceptual issues in evaluating community action were considered. Norman Giesbrecht leads off by characterizing the nature of community action research projects and developments in the field since Scarborough. Next, truly capturing the intended spirit of disclosure, the second paper provides an illuminating Canadian case study of a governmentally instigated prevention initiative and evaluation, candidly describing the problems and dilemmas encountered in each of three involved communities and how some successes are being seized from the "jaws of disaster." Following this, conceptual and methodological issues based on two evaluated New Zealand community prevention projects are discussed, enumerating key features in the approach taken. Lastly, with the benefit of the passage of time, issues in the attribution of program effects in the Rhode Island Alcohol Abuse/Injury Prevention Project are considered.

The second section reports experiences with policy adoption case studies: licensed drinking establishments and antidrinking-driver campaigns from Canada and Australia; two Canadian studies involving program philosophy and politics in the arenas of drunk driving prevention and tobacco regulation; the intersection of community prevention and national politics based on experiences in Israel and Poland; and strategies for implementing local policy change involving reports based on municipalities in Oxford, England, and California. With the perspective of a seasoned campaigner and long time

activist within and outside "the system," Robert Reynolds, in summing up the first day's papers, traces the recent history of relations between researchers and advocates/community activists, highlighting some down-to-earth political practicalities that deserve our full attention.

Community trials design issues are the focus of the next section, led off by Alexander Wagenaar's invited explication of the tradeoffs between scientific requirements and practice needs he faced in designing the Minnesota 18-community randomized trial of community interventions, and how these competing demands were balanced. This is followed by a paper on an ambitious community-based prevention study in Stockholm, Sweden, and one on the Prevention Research Center's 5-year community prevention trial. The next paper in this series gives information on implementation and preliminary findings in the Kirsberg Public Health Project in Malmö, Sweden. The last paper in this section considers the similarities and differences between community-based programs and community action research projects and identifies key challenges in accomplishing the latter.

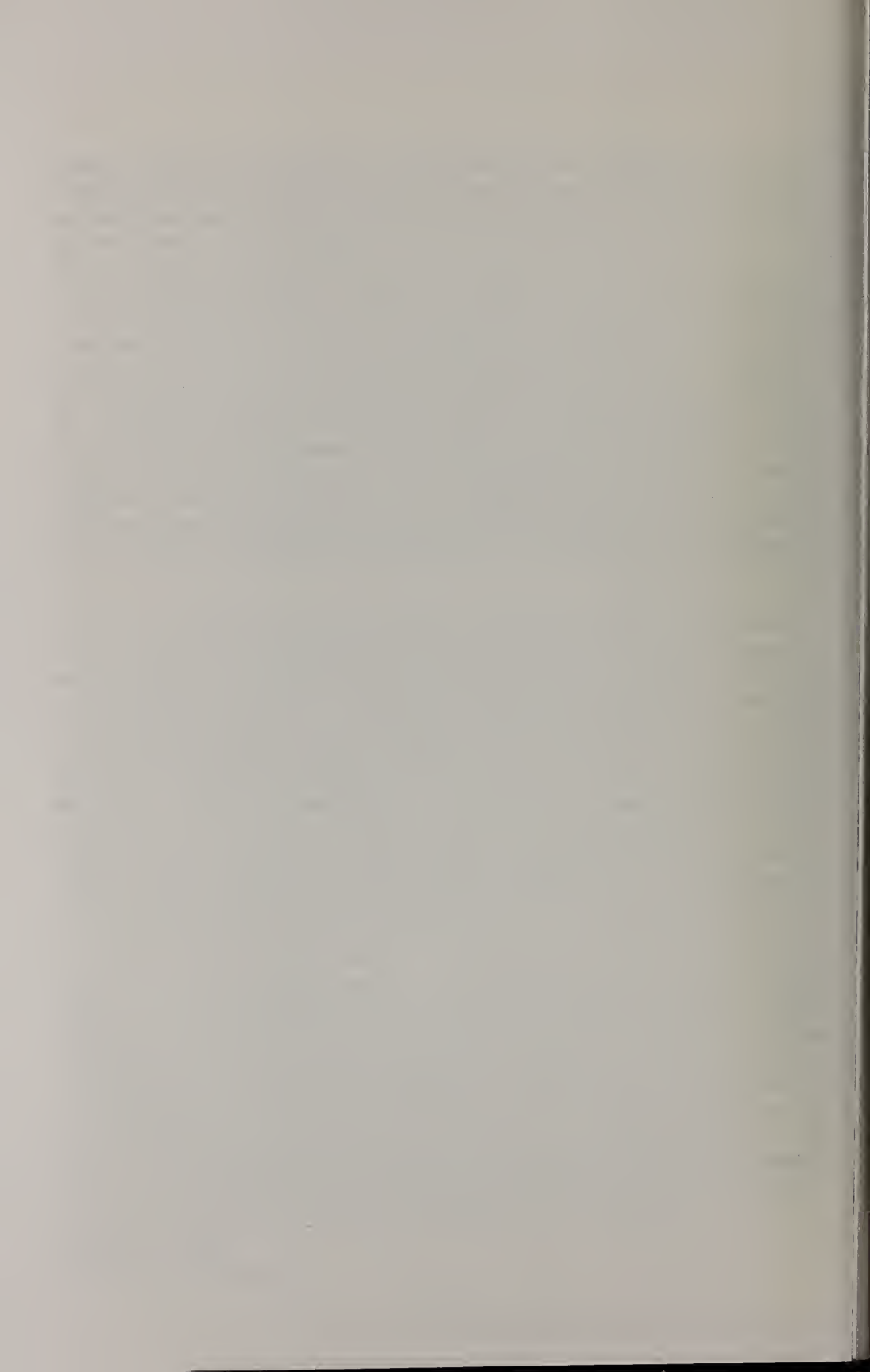
Papers in the fourth section involved needs assessments or natural experiments in special (or, as Jussi Simpura would have it, ordinary!) settings. The needs assessments considered were for Canadian prevention programs for university freshmen and for employees in five workplaces. The naturalistic studies were related to planning environmentally based approaches. Two involved observation of communities ambivalently catering to seasonal intrusions of Dionysian revelers: the celebration of midsummer eve in Borgholm, Sweden, and spring break alcohol promotions in the United States. The third involved street use of Lysol in western Canada. Simpura, in his pithy reflective commentary on the day, introduces the European perspective on community studies and speculates about the possibilities for such community action research in the near future in the era of the European Community with its political and economic shifts.

The next section addresses broad-based programs and their "fit" with grass-roots initiatives with two papers from distinctive viewpoints—that of a national evaluator for the RWJ "Fighting Back" Initiative and of a local evaluator for OSAP Community Partnership programs. These are followed by studies of cross-community differences in response to alcohol and other drug problems in an affluent Western U.S. county including enclaves of less-well-off ethnic groups and sub-localities in an Indian urban slum and adjacent villages. Robin Room sums up the last sections with some thoughtful comments about various models of community action and the implications for the roles of community organizers and researchers.

The final papers involved, loosely, issues related to transfer of knowledge (training) and sustaining citizen/community organization actions. One paper is again based on the Rhode Island prevention trial and how interventions have or have not been sustained. The other evaluates national-level training as a means of enhancing multisite community programs in the United States. In summing up the last morning's papers Sally Casswell considers carefully the vital issue of programmatic ownership and appropriate research strategies including community involvement for securing and then sustaining long-term community change. Lastly, Michael Hilton, taking an overview of the conference, comes full circle from Giesbrecht's keynote paper, addressing tensions inherent in community action evaluation research and exploring recurrent conference themes of tradeoffs, balance points, and compromise—how far can these tensions arc across the poles before the circuit is broken? He identifies a number of other thought-provoking tensions, such as that between researchers and policy makers. Summaries of four thematic workshops held during the conference conclude the monograph.

As with the 1989 symposium, the 1992 symposium was designated as a thematic meeting of the Kettil Bruun Society for Social and Epidemiological Research on Alcohol, which was fitting given the provenance of the idea for the first symposium in discussions originating within that organization. In 1989 as a researcher in a new institute designed to marry research and community action I was fortunate to be at the right time and place to be asked to chair a planning group to develop the second conference. Institutional flux being as it is, especially in entirely new and utopian organizations, I was doubly fortunate to be able to turn to four others for expertise and support. It is safe to say that without their commitment and ability, and the unflagging efforts of the planning group they were part of, this conference and monograph would not have happened. First, Tom Colthurst really organized the symposium, obtained the necessary funding, and made impeccable conference arrangements. Second, Robin Room and Sally Casswell played critical roles in melding the sessions together in a meaningful fashion and formulating the symposium (and hence monograph) design. Norm Giesbrecht came to my aid with his clear thinking and admirable notes at so many points that a genuine continuity between the first and second symposia may be said to be a deliberate byproduct. And all members of the planning group who met by conference call, at the edges of meetings, and by FAX, are to be greatly thanked as well. Finally, without the expert editorial skill of Bob Zimmerman, who came out of retirement for this project, the monograph would surely not have come forth.

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Acknowledgments

The symposium upon which this monograph is based took place from January 29 to February 2, 1992, at the University of California, San Diego, and was made possible by the diligent efforts of a number of individuals and organizations who deserve acknowledgment.

An organizing committee, formed soon after the initial 1989 symposium in Ontario, Canada, was critically involved in the selection of presentations, agenda development, conduct of the symposium itself, and editorial review of these proceedings. Under the able leadership of Thomas Greenfield, PhD, initially with the Marin Institute for the Prevention of Alcohol and Other Drug Problems, San Rafael, California, and now director of the Institute of Epidemiology and Behavioral Medicine, Medical Research Institute of San Francisco, California, and senior scientist, Alcohol Research Group, Berkeley, California, the committee also included:

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Three public agencies provided financial support, for which the organizing committee was most grateful. Health and Welfare Canada's Health Promotion Directorate assumed the costs of international air travel for select participants from outside North America. The National Institute on Alcohol Abuse and Alcoholism likewise paid for transportation and lodging expenses for certain scientists not otherwise able to participate. The Office for Substance Abuse Prevention funded preparation of the manuscript for this monograph.

The University of California, San Diego, was host for the symposium, through its Extension Department's Alcohol, Tobacco and Other Drug Studies unit. I extend a special thanks to my UCSD colleagues, Liz Estrella, Barbara Ryan, Cindy Sullivan, and Robert Zimmerman, for their fine work in planning the meeting and tending to aftermath tasks.

The organizing committee is pleased that it was possible to arrange the symposium as a thematic meeting of the Kettil Bruun Society for Social and Epidemiological Research on Alcohol and appreciative for the interest of society members in this event.

*Tom Colthurst, Director
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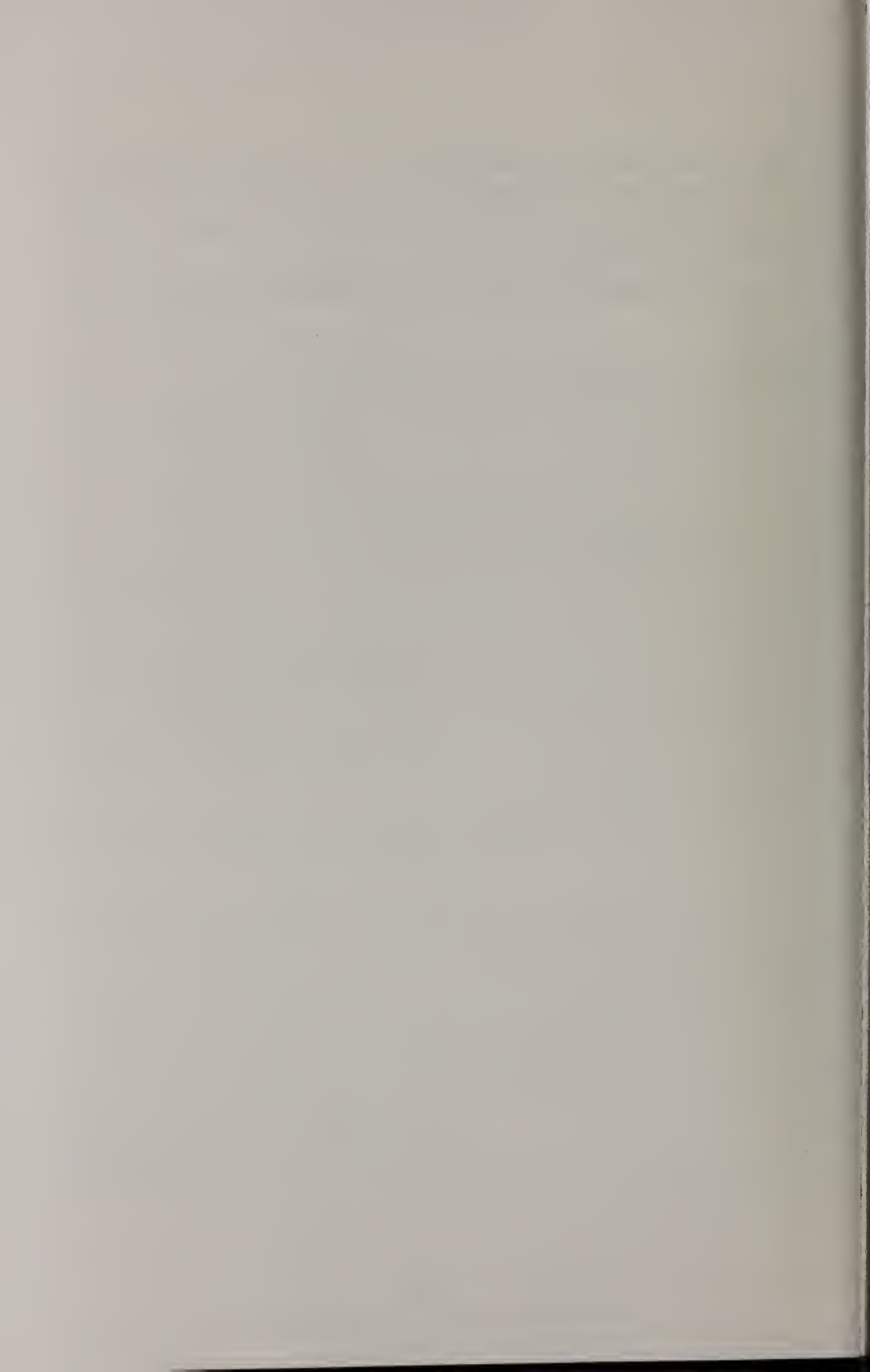
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CHAPTER 1

Conceptual Issues in Evaluating Community Action

Keynote: Community Action Research Since Scarborough; Key Issues Facing Us in 1992

Norman Giesbrecht

The organizers have chosen a very large topic for these opening remarks. This topic would have been marginally easier to tackle had I been allowed the advantage of lurking around over the next few days and overhearing coffee or tea break conversations; in other words, to make the presentation at the end of the symposium. Another alternative would have been to visit several sites where new projects have been initiated, although budget constraints make this a highly unlikely option.

Communication specialists refer to audience segmentation. It is feasible that during this week we can consider four types of participants in this meeting: the curious, the committed, the cynical, and the concerned. These might be illustrated as follows:

- *Curious* —What is this symposium about anyway?
- *Committed* —Will my views be supported?
- *Cynical* —Isn't San Diego a great place to visit?
- *Concerned* —Will the presenters please keep the project skeletons in their designated closets?

Well, let us hope that over the next few days at this symposium there is a little something for everyone.

Nature of Community Action Research Projects

It is worth asking the question: Why strive to combine action and research? A key reason is that conventional research approaches are inappropriate for evaluating community programming and processing. An equally important reason is that community programs typically are not adequately evaluated or monitored. However, the most important reason is that by combining them we might expect that both action and research will be enhanced. Not only will there be a greater overall impact on alcohol and other drug problems in the

community, but outcomes and process will be documented so that other projects and communities can benefit from the experience. This is the ideal.

Community action research thus strives to combine the benefits of appropriate and thorough evaluation with those of powerful community-based prevention programming. However, as indicated by Robin Room (1990), this is an "unstable mixture." It is perceived as impermanent, often unequal and volatile. Research protocols are expected to constrain the dynamic, unconventional, or even dramatic aspects of effective programming, whereas giving free rein to programming will likely confound the designs and methods so highly valued by researchers.

The two key components of action research are community initiatives and research. Bringing these two together involves tensions and protective stances, as well as flexibility and the ability and willingness to negotiate (Room 1990). In basic terms, the community action component must be allowed the latitude to flourish, which requires that research design, methods of data collection, and even timetables and logistics must be planned with this flexibility in mind.

Of equal importance is the flexibility required from a community development orientation. For example, looking for creative implementation scenarios or methods that will not confound the evaluation or monitoring (or at least will minimize contamination) and still deliver the desired impact is an important means of responding to the combined agenda of these projects.

This dynamic tension was central to the deliberations of the 1989 Scarborough meeting, and was reported in the monograph based on this meeting (Giesbrecht et al. 1990).

In rereading a number of the papers from the first symposium, it struck me that we may be experiencing an evolution in bringing together research and action, involving changing and likely overlapping scenarios: separate and different; different and partly combined; and combined action throughout.

Separate and Different

In the first scenario researchers handle one aspect of a project and action persons handle another. Thus, two quite different approaches are largely forced together, or mixed together, in an "unholy alliance" in order to try to get the job done.

Different and Partly Combined

In this second scenario more attention is given to how the whole differs from the parts. A key focus is what can be done to plan for and accommodate the difficulties related to the largely unplanned or ill-prepared bringing together of different expertise, approaches, traditions of planning and decisionmaking, and ideologies.

Combined Action Throughout

The third scenario involves the careful planning of a joint undertaking from the outset. The ideal is that all participants defend and support the central distinctive nature of these projects. Thus, researchers defend the action component, and action workers, the evaluation. Not only do they protect their conventional "turf," but they also promote the project per se.

This arrangement does not *downplay* the important contributions of special skills in mobilization, local organizing, needs assessments, evaluations, or intervention planning. However, in this scenario each specialist has a stake in the whole as well as the successful execution of the components. What does this mean?

It means, for example, that the researchers appreciate the *unique* opportunities these projects offer in encouraging local visions, procedures, programs, and action. It also means that community change agents appreciate the unique benefits of locally based epidemiological data and assessment of the impact of local initiatives, even if their preferred programs do not end up with the impact expected.

This shared commitment provides a basis for defending the unique contributions by all persons working on the project. An important step toward sharing in protecting the essential components of the project is to learn more about the unique contributions of fellow cospecialists.

What Is Unique About the Research?

To conduct research in combination with action and to measure the processes and outcomes of these actions require, at a minimum, being cognizant of the levels of local action and activity; using a multiplicity of methods and techniques; and showing flexibility and facility in coordination.

Levels of Local Action and Activity

While there are many ways of disaggregating the local scene that is the context of a community action research project, I'd like to point briefly to four:

- *Environment*—Mores about drinking and abstinence, distributions and sales arrangements and procedures, and promotion of drinking or healthy practices are key considerations.

- *Structures and institutions*—These include, for example, conventional arrangements for responding to alcohol issues, handling heavy drinking, and managing the consequences of drinking.

- *Groups*—The influence of ad hoc organizations on policies and programs or on heavier drinking cohorts in setting the pace for lighter drinkers is an important consideration.

- *Individuals*—Information on key power brokers or opinion leaders and their experiences on alcohol issues, which shape the acceptance or rejection of interventions, is critical to the project.

Multiplicity of Methods and Techniques

Tracking these and other changes in dynamic contexts requires a multiplicity of methods and techniques. The following are being used and/or might be considered:

- Trend analyses of aggregate statistics on, for example, alcohol sales, casualties, public drunkenness events, and hospitalizations.
- Surveys of general or special populations using, for example, repeated random samples or panel studies.
- Monitoring of views of key opinion leaders or orientations and activities of special interest groups.
- Ethnographic methods to monitor perceptions, interventions, and focus behaviors.
- Documentary methods to monitor institutions, their clientele, and procedures for responding to alcohol issues.

Flexibility

This quality is required at all stages of research planning and implementation. It is necessary to coordinate multiple monitoring, documentation, and evaluation protocols, and to build in safeguards so that monitoring does not create artificial results or impede community action.

What Are Some Key Aspects of Community Action in the Context of These Projects?

Competing Agendas

It is highly likely that competing agendas will emerge as these projects evolve. At a minimum, new initiatives will likely be a threat to the turf of established institutions, not only those involved in alcohol sales, but also, possibly, treatment and information-based prevention efforts.

Furthermore, local *wants*, that is, perceptions of key problems, may be some distance from actual experiences. For example, groups at high risk may be ignored, and those at lower risk may be presented as the most critical. However, the limitations on resources (in terms of paid staff, volunteers, and the time local professionals can contribute to the project) will *accentuate* the need to bring together local needs with what are perceived as optimum interventions.

Multiplicity of Interventions

There is a growing belief, based in part on experiences with cardiovascular problem prevention projects and the logic of the interconnectedness of alcohol-related problems, that multiple interventions have greater potential than single focus interventions. The topic of multiplicity of interventions raises a number of issues that need to be considered when developing the intervention protocol:

- In light of local resources and infrastructure, what are preferred scenarios for the combining, sequencing, or stepwise building of interventions?
- What knowledge base, technical aid, or other resources are required to enhance the interventions and the overall strategy?
- How can vested interests be turned to facilitate rather than confound new prevention efforts?
- Which interventions should be introduced at an earlier phase of a multi-component intervention program, so that broadly based support is eventually developed?

Coordination

Of equal difficulty are the requirements to be both intensely involved in the day-to-day action enhancement activities and also to step back to see the relative importance of these components in terms of their contribution to the overall goals of the project. As a colleague said recently, "Everything seems important." The complex nature of these projects dictates that timing and priority setting are ongoing central demands of the action component. Unfortunately, retrospective insights on priorities are relevant for the next generation; many key decisions about the project need to be made when the project is in progress, not after the fact. If we can use a simple analogy, pilot studies for parenthood might be useful but socially unacceptable.

Potential

These projects have a great deal of potential in the following four general areas: (1) prevention and health promotion; (2) changing perspectives and practices; (3) enhancing participation and delivery; and (4) dissemination of outcomes and products.

Prevention and Health Promotion

These projects can have roles (both at interim or at completion) in health promotion or prevention:

- Enhancing health practices.

- Increasing protective resources.
- Reducing the prevalence of users.
- Delaying the onset of use.
- Decreasing the number of occasions of high-risk use.
- Reducing the number of high-risk users.
- Decreasing the rates of dependency.
- Lowering the rates of mortality and morbidity.

Changing Perspectives and Practices

These projects provide an opportunity to introduce new perspectives on alcohol and other drug issues into the community, and to provide guidance with regard to the following: Which drugs cause the majority of the problems? Which groups are at high risk? What are the appropriate and most potent interventions?

These projects also provide an avenue for promoting responsible attitudes and practices in the community with regard to alcohol and other drugs.

Enhancing Participation and Delivery

Community development should be a key aspect of these projects. As part of the process and outcome of these projects, there should be greater community involvement in alcohol and other drug issues.

Through its implementation, the project should enhance local procedures for developing policies, programs, and services. While these procedures might have been energized or streamlined in the course of such a project, it is hoped that a positive legacy will be provided for the community in the course of the project. Furthermore, it is hoped that greater local or regional facility in handling alcohol and other drug problems will emerge in the course of the project.

Finally, an appropriate goal, both at interim and completion, is that of providing more effective and appropriate programs and services.

Dissemination of Outcomes and Products

These projects typically are also explicitly designed for demonstrating their potential for use in other places and settings. This task might be done by sharing, through reports and papers, experiences, protocols, expertise, and materials to provide an effective dissemination of the key process and outcome findings of the project.

A number of levers are at the disposal of the community and the change agents to achieve some of these goals, including those focusing on environment, structures and institutions, groups, individuals, and substances. While some specific levers are, strictly speaking, outside the scope of a local group or organization, awareness of issues and lobbying for State or national change is not inconsequential. Raising the consciousness of local politicians with regard to alcohol policy issues, for example, will likely provide an avenue for influencing higher levels if and when these politicians move up or, alternatively, are involved in lobbying Provincial, State, or national decisionmakers (Douglas 1990).

Progress

Over the past years there has been progress in a number of areas. In some cases this progress has involved increased local awareness of alcohol or other drug issues and, in other cases, improved delivery of services, enhanced community mobilization, or even reduced rates of problems. With the caveat that the following comments may reflect a peculiar parochial bias, I would like to note that we have seen progress in the following:

- Reduced rates of drinking and driving.
- Expansion of server intervention programs.
- Greater interest in workplace programs.
- Efficacy of short-term counseling for those individuals beginning to have problems.
- Programs for special populations.
- Growing awareness of the role of alcohol in cases of trauma and violence.
- Involvement of health professionals in the delivery of alcohol programs.
- Municipal interest in alcohol policy issues and development of management strategies.

These developments provide a rich basis for community action projects. At the same time they can also confound the evaluation of these projects. Separating gradual secular changes in mores about alcohol and an interest in prevention, on one hand, from the specific interventions of a project, on the other, is likely to be very difficult and frustrating.

Of particular interest is the consumption of alcohol by young adults, particularly young men. This population—roughly ages 20 to 35—represents a large share of the total alcohol-related problems on a number of measures, such as accidents, violence, trauma, and so on. Greater attention to this subpopulation is clearly warranted. A substantial reduction in consumption

and the related consequences in this subpopulation would be a significant achievement.

General Changes

A growing interest in prevention activities in general and in these projects in particular coincides with some broader secular changes. Some of these changes are pulling in opposite directions and vary by region, country, or geopolitical area.

- Changing rates of alcohol consumption are evident; for example, they are falling in North America and rising in Eastern Europe.
- In a number of countries or regions there are explicit efforts to curtail or reduce the scope of monopolies and moves to privatize distribution and control arrangements.
- Efforts to eliminate trade barriers and further integrate alcohol industries cross-nationally have been under way for some time.
- There appear to be intensified efforts by the alcohol industry to promote alcohol sales by introducing new products and by sponsoring sports and music events.
- There is evidence of growing public awareness of tobacco, alcohol and other drug issues, and drinking-related problems. Since the 1960s the range of perceived problems and perceived groups at high risk, as well as environmental conditions that are seen as promoting problems, has increased dramatically. Health promotion and prevention advocates are looking to the lessons from tobacco-control experiences. In recent Canadian and U.S. surveys there appears to be substantial support for several alcohol control policies (Giesbrecht and Greenfield 1992). Also, there may be broadening public cynicism about at least the most blatant alcohol sales promotion efforts.
- There are moves toward a decentralization and commercialization of health services.
- There are local community action projects, as well as more centralized initiatives, on a number of other health issues, which will likely have "spill-over" effects on projects that focus on alcohol and other drugs.
- The recession with its multiple and divergent implications also affects these projects.

Implications

I would like to propose, in a preliminary way, some implications of these developments for community action research projects.

- The decline in alcohol consumption and increased public awareness of alcohol issues may make it more difficult to separate the unique effects of project interventions from secular trends, and, furthermore, are likely to produce increased underreporting of heavier consumption or drinking-related problems.

- Locally based alcohol management and control efforts are likely to be of particular concern to the alcohol industry and to local businesses that rely on alcohol sales for a share of their profits. These two entities may exert strong pressure on municipalities and/or project directors to steer them away from alcohol policy areas.

- A growing awareness of alcohol problems may make it more difficult to find comparable communities that are not already involved in prevention efforts. Nevertheless, once these communities are identified it will be easier for local change agents to encourage local interest in prevention programs.

- Recessionary forces may reduce the implicit ranking of social issues and problems at local, regional, and national levels. Furthermore, there may be fewer local resources to deal with these issues or greater resistance to interventions that may reduce alcohol-related problems but also negatively affect alcohol commerce and trade.

In conclusion, community action research projects, by their nature and in light of these conditions, provide special challenges to their sponsors, to the community groups, to change agents, and to researchers. The overriding challenge is for these contributors and participants who bring with them different agendas and perspectives to work together effectively to promote health and to reduce alcohol and other drug problems, and to document and demonstrate such positive changes.

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Symposium Plenary Discussion

Jan Howard opened the discussion period with the observation that the National Institute on Alcohol Abuse and Alcoholism encourages research that looks at the interaction of interventions and at multiple interventions but acknowledges that there is little likelihood that anyone would take this beyond two communities. When thinking about "packaging" these models for communities or States to use in the future, she said, an important question is, What needs to be packaged? "Each of these interventions is costly, and communities are going to ask in a very common sense way, what can we do without? We can't really answer that question very well with current designs." She added that there may be a contaminating factor in control groups when government actions on such issues as taxes or the minimum drinking age become universal and have an impact on general alcohol consumption.

Giesbrecht responded that two methods could be used to find out what combination of interventions might be optimal. One method is to find out what people in a community believe about the impact of various interventions that have been employed at the same time. The other method is to conduct very expensive trials. "What I was striving at is a third that I think needs to be explored," he said. "Based on theories of social or individual behavior change, what logically would seem to be a more reinforcing combination of interventions than others—such as mass media followed by regulatory measures, and so forth? I raise this as an area where there seems to be a big gap in the literature."

Friedner Wittman mentioned two policymaking issues that he hoped the symposium would explore. First, there is a need to look at the locus of policymaking at local, State, and national levels. "We need to keep in mind the policymaking audience for what we're doing," he said. Another issue is the tension between researchers and programmers. "The bureaucracies that pay

for research often have very different interests than the program agencies and politicians who want results from a program's interventions."

Tom Greenfield, who presided over the session, noted that the symposium planning group had discussed the latter point, but it would have been difficult to involve more program people without making the meeting much larger. Hari Kesh Sharma remarked that in India he had found that policymakers often are "not sure of themselves" when confronted with research evidence that suggests a course of action and may choose a course irrespective of the scientific evidence.

Continuing this discussion, Diane McKenzie said she believes researchers need to "get inside the policy process" and learn how to work within that system, something that few researchers have an opportunity to do. Robin Room said that when policymakers ask whether there is any published research about a particular question, the answer often is no. On the other hand, researchers do not often make policy questions part of their research agenda. There needs to be more openness on this issue on the part of researchers as well as policymakers, Room said. It should not be regarded as a bothersome "boundary" encountered from time to time.

Ron Douglas asked whether researchers might be falling into the trap of "blaming the victim" in this respect—the victim being the policymakers or the bureaucrats, who are blamed for "not doing what we want (them) to do." The real questions are, Why aren't we reaching them, why aren't we motivating them in the direction we want them to go? "What's wrong with us, not what's wrong with them?"

Greenfield said this discussion raised the question of the definition of community, which had come up repeatedly at the Scarborough symposium. The community is part of a larger system. "If your methodology focuses on action locally but does not take account of constraints in the political process happening at another level, you're accepting boundary conditions that are going to limit your action," he said. It becomes an issue of how local actions amplify a national action or, conversely, what local actions might make a difference at the regional or national or even international levels.

Prevention at the "Grassroots": Problems in Planning, Implementation, and Evaluation

Louis Gliksman and Margaret Rylett

The Ontario government, in response to public concerns about the spread of illicit drug use, created the Provincial Anti-Drug Secretariat (ADS) to oversee efforts in this domain.¹ In addition to looking at treatment efforts with respect to illicit drugs, the ADS decided to provide money to six communities that were at risk to develop and implement prevention programs designed to combat this problem. A total of \$4.5 million was made available to fund these efforts for 2 years. Part of this budget was intended for evaluating the efforts of the individual communities. At the request of the ADS, and with the strong encouragement of the Addiction Research Foundation (ARF) management, we prepared and submitted a research plan and budget for evaluating these programs. When the research plan and budget were requested, the program plans did not exist. In fact, the communities had not even been chosen. Our plan was, of necessity, generic.

The evaluation research would have four phases to it. First, we would conduct a community-based needs assessment in each selected community. This needs assessment would be based on a model of health promotion supported by Health and Welfare Canada and would document what programs and services currently exist in each community, what the needs and problems are, and what program and service gaps need to be addressed. This report would serve as the basis for the community groups to begin their program planning phase. Second, we recognized that the government intended to "empower" the people, and that the project and activities were to be community driven. This meant that each community would organize things differently. Therefore, we wanted to monitor how these communities mobilized themselves and the progress they were making. Third, we would evaluate the projects that would be developed (by designing individual evaluation protocols) to determine whether they were getting to their intended targets with their intended impact. Fourth, we would evaluate the overall impact, in terms of changes in problem indicators and community attitudes and norms, of the 2-year program. Our evaluation research included formative, process, impact, and outcome components. We would provide ongoing feedback to the community coalition to indicate their successes and failures so that they could correct problems as they occurred. The research design that we submitted, while not complete with specifics, did emphasize the need for control communities, which would require data collection and monitoring, and control strategies for the evaluation of certain projects that would be implemented.

Complex Issues

From the outset, we have had to deal with complex and challenging issues. The following is a discussion of the dilemmas that confronted us and how they were resolved. Please bear in mind that political, community, ethical, and research issues often conflicted.

The ADS expressed concern over the size of the budget, and asked us to conduct the study without control communities. Arguments about the need for internal validity fell on deaf ears in the face of fiscal reality. We were faced with the choice of cutting the budget by cutting control sites or refusing to conduct the study. It must be remembered that the ARF at the time was a sister agency to the ADS and cooperation was expected. Not conducting the study would have been politically unwise, given the public commitments the government had made. The ADS was willing to accept a less than ideal design in exchange for a large budget reduction. We accommodated the budget concern, but built in multiple community responses to allow for trend comparisons within each community. Across all the sites, we would have 36 observation points for our analyses, which would allow us to talk about overall changes in the communities, although we would not be able to attribute the changes directly to the program.

Part of the ADS request was that we help select the six communities that would be targeted. Prior to making this request, the ADS had compiled a list of 17 communities that the government ministers felt should be included. This list was based on an initial list of about 86 communities that were nominated through an interministerial request. Our task was then to rank these 17 communities. We developed a set of criteria that focused on need, the existence of an infrastructure in the community, and the feasibility of doing any programming. We collected the data along these dimensions and provided our recommendations for the six communities. For a variety of reasons (e.g., the media making drug problems synonymous with specific communities and the need for some ministers to pump money into their jurisdictions prior to an election), the number of communities increased to seven, then to eight, and finally to nine—some of the communities chosen had not even been ranked in the top ten. While our budget for the evaluation changed, the change did not reflect the 50-percent increase in the number of communities that were now part of the study. Again, the expectation was that we would accommodate this relative decrease in the budget—which, in fact, we did.

As part of the evaluation process, we insisted on collecting baseline information about the communities and their residents. We suggested that the baseline collection include a community-based needs assessment component that would articulate community concerns and indicate where priorities should be placed. The assessment was based on a model of health promotion and

prevention that included individual targets, environmental targets, and drug targets. It took several presentations to convince the ADS that this approach would work, and that it would not be perceived by community residents as usurping their role. The needs assessment component was included in the design.

The ADS mandate was limited to drugs and this limitation was stringently interpreted to mean illicit drugs. At various presentations the ARF, while not dismissing the harmful, dangerous effects of illicit drugs, indicated that alcohol could not be ignored. Although some accommodation to alcohol was made, particularly in the case of youth for whom alcohol is an illicit substance, it was clear that the primary focus was to be on "street drugs." In order to ensure that alcohol issues and the impact of general health promotion programs on this substance were addressed, we included alcohol questions in the needs assessment instrument and in the community surveys that followed.

Once these preliminary decisions had been made, we were ready to begin with the needs assessment. Unfortunately, the process of community selection was delayed for so long that our needs assessment could not be conducted before any program planning was to begin. Because of budget concerns, money had to flow by a certain time and could only be released if tied to specific interventions and budgets. Thus community groups had to develop at least a rough plan in order to receive funding.

The ADS was unable to delay the process because they had announced the nine communities that would be funded, and their residents were waiting for programs to begin. Unfortunately, the development of the program plan and the needs assessment had to occur almost simultaneously. Therefore, the needs assessments could not be tailored specifically for each community. While this proved to be advantageous in that we were able to produce a generic instrument, it was a liability in that we could not ensure that a representative community sample would be chosen. It is interesting that although the samples were chosen solely to ensure that ethnic, gender, and age groups were represented, the demographic characteristics of the samples indicated that we had achieved a representative sample. Again, even though the needs assessment provided a wealth of data about how the community was perceived by its residents and where they felt the priorities should be placed, the timing of the announcement and the need to have a plan on which to base financial decisions meant that the needs assessments could only be used to modify existing plans and could not serve as the basis for an original plan. It is human nature to commit to a plan that you have been involved in developing, and only in those instances where obvious problems exist will changes be made. This is what occurred in most of these communities.

As soon as the plans were completed, and prior to funding, the ADS asked us to review and comment on the program plans. As outside evaluators, we

believed that this request was one we could not accommodate because of the contamination effect. Also, we did not want to be perceived as driving a community-driven program, which would damage our relationship with the community coalitions that had been formed to provide the initiatives. We chose to stay in our research role—something we have had to reinforce over the life of the program. This hands-off approach has been particularly difficult to maintain in the face of the manner in which some of the coalitions have been run. In many instances they are run by lay people who have little knowledge or skills in the addictions area or in health promotion. In other instances the coalitions are agency driven and appear to more concerned about developing and implementing programs that are consistent with the agency's unique concerns and issues. Although ARF program consultants are available as resources for program planning, most coalitions have not used them in this capacity. In these cases we have had to restrain ourselves from directing coalition attention to specific programs and interventions that we believe might fit the needs of the community residents.

Problems Encountered

The project has really been in operation for just about a year, and we have been involved in the data collection phase for the entire period. Numerous problems have been encountered in even this routine aspect of the study.

Each of the nine communities was required to hire a program coordinator who, while in charge of the day-to-day logistics of implementation, was answerable to a community coalition, a coalition that was often less representative of the community and more representative of agencies. One of the things that we negotiated was that the coordinators were to keep us apprised of when an intervention was to be implemented and what the intervention was to be. While we had a general plan for each community, most of the plans did not have time lines, and even those that did tended to have flexible time lines. We were to receive this information well in advance of the event in order to put together an evaluation plan. In most instances we received the information just prior to the event, and in some instances we did not find out about the event until after it occurred. In order to minimize the loss of information about events, we developed generic questionnaires that dealt primarily with process and that could be administered by the person running the event, if we were informed too late. This process seems to have worked well, and most coordinators are using these forms and then submitting them to our office for analysis. In fact, we are now seeing the fruits of these efforts. Coordinators look forward to receiving our reports of their activities, so that they can make necessary changes and learn from the data that they have had a hand in collecting.

Our office is physically removed from all the communities, in some instances by as much as 500 miles. Therefore, we do not have direct control over the collection of data. In some instances, such as that described above, we have

relied on coordinators to ensure that people running the simple interventions, which are the staple of the programs, collect the data. This practice appears to have worked well. In other instances, such as the needs assessments and the semiannual surveys, we have needed a cadre of staff in each community to be trained in face-to-face interview techniques to collect the data that will provide information of overall community impact. In order to do this, and in accordance with our promise to the ADS, residents of each community are hired and provided with detailed instructions. We rely on the coordinators to arrange for our interviewers, which has worked well in most instances. We now have a battery of interviewers for each community who are familiar with our techniques and who are generally available to work for us on relatively short notice. In some instances, despite the best of plans, issues arise that force us to scramble and improvise, and hope that we are able to capture the essence of the program.

At times we have been asked for information that would be used in a fashion for which the data are not intended. For example, on one occasion we were asked to document the work done by one of the coordinators so that termination procedures could be implemented. In these circumstances, we have not collected any new information nor presented the information we had so that it could be used directly in the manner requested. The data we collect are the property of the communities and accessible to the ADS, but only in the form of reports that are consistent with the research agenda, and not for agendas served by nonresearch-, nonprogram-related requests.

Dilemmas for Three Communities

Each community is unique, and each experiences its share of problems as it strives to fulfill the mandate of the ADS grant. Each community has experienced its share of dilemmas. The following are examples of three different communities and problems with which each has grappled. They have caused problems for us and have even made us rethink elements of the design and the evaluation of the project—and even what was important.

Community A

This public housing complex houses some 12,000 residents in a two-block radius. The needs assessment showed that residents of this multiethnic community had an average of only a sixth-grade education. This level of education presents many difficulties when planning and implementing a project as complex as this. Not only are these residents experiencing the stress of living in a high-risk environment, they do not always grasp completely the extent of their danger or understand the prevention concept and how to implement it. This situation is complicated by petty obsessions around who participates, where meetings are held, and by personality conflicts. An example of this occurred at a training session for the semiannual community

survey on November 27, 1991. The day started with a conflict between one of the potential interviewers and the Focus Community coordinator. The woman was asked to leave, but she refused. Almost an hour was taken up with attempts to have this woman leave the session. Eventually she did leave, but this did not end the affair. On November 29, the coordinator telephoned to say that the woman was laying charges against her, claiming that the coordinator "dragged her from the meeting." We were asked to submit a letter recounting the events of this session—which we did. In addition to those complications already mentioned, this community suffers from the presence of too many agencies and services. That is, many activities and services are available that are in themselves valuable; however, no attempt has been made to coordinate these services, to avoid duplication, and to promote them effectively to those most in need. Some attempt is currently being made by the Focus Community coalition to address this issue.

Community B

This is a native community of approximately 850 persons. Because of the recent election, the semiannual community survey was postponed. The survey was done by telephone during the 2 weeks following the election. The change in local government meant that we have had to renegotiate both the program commitments and the role of the evaluation. This process has proved to be difficult because the new chief is of the "old school," entrenched in preserving traditional ways, and has made working in the community more difficult. In addition, a number of individuals have used the semiannual survey as a vehicle through which to voice concerns about the changes that have been taking place in the community since the election. We do not know the extent to which these statements are true, but the fact that they were voiced in some manner by individuals indicates there is concern—concern that may affect the quality of programming and our ability to collect data in this community. Negotiations have been taking place with the chief, but to date no agreements have been reached.

Community C

This multiethnic public housing complex is composed of row housing and apartment buildings. There are about 2,100 residents. A number of seniors and disabled persons live in this complex. A centrally located community center appears quite new and is reputed to be "the most underutilized facility in Toronto." The Focus Community coalition mainly comprises agency representatives and the like. Because the mandate for this project is based on grassroots community involvement in the planning phase, three community residents were invited to sit on the coalition. For reasons not readily apparent, this coalition has been slow in reaching consensus about a program plan. Furthermore, there appear to be ongoing power struggles. Once a program plan was documented and funding allotted, little was actually done to implement

the programs. The first obstacle to program implementation was the hiring of a program coordinator. Only a few applications were received, and, of these, few candidates were well qualified for the position. Despite considerable disagreement among the coalition members, one candidate was hired. He was a minority group member and has since attributed the lack of cooperation exhibited by this coalition to racial prejudice. Indeed, there have been several incidents that clearly demonstrate that racial discrimination is an accepted behavior in this complex. At the very least, there is a paternal attitude among coalition members regarding the ability of minority residents to hold their own meetings and direct their own activities. At the most, there have been overt acts of hostility shown to the minority group babies and toddlers in the preschool and physical attacks on some of the mothers attending classes in English as a second language. In addition, the coordinator and his secretary have charged each other with sexual harassment. It is believed that the antagonism that exists between these two individuals is related to the class positions each held before emigrating to Canada. The female secretary believes she is from a higher class than the male coordinator, who adheres to the dominant-male model embraced in many societies. Added to these difficulties, the coalition apparently regrets its decision to hire him and is actively seeking opportunities to prove he has not fulfilled the obligations of his contract—which still does not exist. At the same time, he is actively pursuing political and medical strategies to avoid being fired. According to this coordinator, “a great deal of programming money is actually being spent on legal fees.” With all this conflict, it is clear that offering activities, raising the level of awareness in the community, and involving the residents in the decisionmaking process are a distant priority at this time.

Successes Noted

Although the issues are complex and the problems experienced are potentially serious, the program has not been without its successes. Generally, all nine communities have succeeded in increasing awareness of the issues and getting involvement from the communities. The second community survey, which has just been completed, indicates a shift in the social norms and attitudes in some of the sites. Whether these changes persist or become even more pronounced will be monitored, and attempts to relate these changes to programming will be made.

Despite obstacles and problems and compromises, it appears that a research agenda can be maintained, and in fact must be maintained, to ensure that community successes are documented and the results shared with other similar communities. Often it is much easier for the researcher to back out of the project because its pristine internal validity cannot be guaranteed. In fact, had it been possible, we likely would have backed out of the current project. The challenge is to be creative, to accept what is possible, to argue for what must be

maintained, to recognize what is not possible, and to ensure that the appropriate caveats about the design and the data are made clearly. Some information that is clear and beneficial is crucial to the program and to others who hope to duplicate these efforts—even if that information is not as perfect as one would like.

Note

1. The ADS has recently been disbanded and its responsibilities distributed among a number of government ministries.

Evaluating Community Projects: Conceptual and Methodological Issues Illustrated From the Community Action Project and the Liquor Licensing Project in New Zealand

Paul Duignan, Sally Casswell, and Liz Stewart

Introduction

This paper is based on work undertaken by the Alcohol and Public Health Research Unit (formerly the Alcohol Research Unit) in New Zealand. This team, directed by Dr. Sally Casswell, has been involved in evaluating community prevention projects over the last decade. The two projects used as the basis for this paper are first a demonstration project, the Community Action Project (CAP), and, secondly, a followup project utilizing the community organization strategies developed in CAP: the Licensing Project.

The Projects

The CAP was a large-scale, medium-term quasi-experimental demonstration project focused on community attitudes toward alcohol control policies, which ran from October 1982 to February 1985. It compared intervention by means of mass media campaigns in two cities (media intervention) with the same media campaigns plus community organization by an alcohol health promotion worker (alcohol worker) in each of two other cities (intensive intervention). These four cities were also compared with two other cities that were not exposed to either intervention (reference cities).

The major thrust of the community organization component (which included media advocacy) of the program was to stimulate consideration of alcohol policy issues in the community. Throughout the program an attempt was made to focus on policy issues, while recognizing the alcohol worker's status within the local community, which meant that her or his activities required the support of community coworkers.

Evaluation of the project consisted of formative evaluation input into project development, regular meetings (at least bimonthly) between the alcohol workers and the researchers, and quantitative and qualitative developmental research on the television and radio advertising campaign. Process evaluation consisted of documenting the project through key informants' interviews, participant observation, reports from those working on the project, and minutes of meetings. A series of street interviews were carried out and observations were made in licensed premises to check on the level of advertising at point of sale.

Outcome evaluation of CAP consisted of general population surveys carried out before and after the program. Random samples of 600 people were contacted in each of the six cities, using a heavily stratified cluster approach, and respondents were interviewed face to face by trained market research interviewers. Identical sampling methodology and an almost identical structured questionnaire were used in the surveys of independent samples, which were carried out before and after the program.

The results of the project are summarized in Casswell and Gilmore (1989) and Casswell and colleagues (1989). The community organization aspect of the program has been summarized in Casswell and Stewart (1989) and the mass media element in Casswell and others (1990). The aftermath of the project is described in Casswell and Stewart (1990).

Following the conclusion of CAP, a number of positions were established in New Zealand for alcohol workers. The main sources of funding for these workers have been the Alcoholic Liquor Advisory Council (the government body set up to reduce alcohol-related problems), local health authorities, or other government funding agencies. In 1989 a new piece of alcohol legislation was introduced in New Zealand: The Sale of Liquor Act. Although this legislation increased alcohol availability, it also provided, at least in theory, for the possibility of increased community input into licensing decisions. In order to maximize such public health input into the licensing process, a project was set up aimed at facilitating networking between those persons in existing alcohol worker positions. This Licensing Project consisted of approximately six monthly meetings of the 19 or so alcohol workers in positions throughout New Zealand. At these meetings the researchers played a formative evaluation role. In this case, the researchers assisted with specifying objectives and developing strategies that would most likely promote the input of public health issues into the evolving licensing system that has gradually been emerging under the new legislation.

Data were collected for the formative evaluation through questionnaires sent out to the alcohol workers at regular intervals, observation at the formative evaluation meetings, and analysis of documents provided by the alcohol workers. Formative evaluation reports were provided to the alcohol workers at regular intervals. A complementary process evaluation took place, which incorporated document analysis, information from the formative evaluation stage of the project, and interviews with key informants in four cities in New Zealand. The initial set of key informant interviews was followed by a second set after 12 months. The formal stages of this project are now concluding, and data analysis is in progress.

Lessons Learned From CAP and the Licensing Project

A number of lessons were learned in the course of CAP and the Licensing Project. Given that the unit's research task was to evaluate community projects,

we will first describe what we learned about evaluation and then outline what we learned about a community approach.

Evaluation

While working on these two projects we found it important to use an evaluation framework that takes into account the reality of studying alcohol problem prevention in the community. In looking at the research literature for a suitable framework for evaluation, we had to move away (as have many others) from the model provided by the outcome evaluation aspects of biomedical clinical trials.

Community alcohol problem prevention has demanded a flexible and broad approach to evaluation drawn from modern applied social science evaluation methodologies. The area has demanded early evaluation input; qualitative, as well as quantitative, methods; process in addition to outcome studies; realism about the possibilities for using control or reference groups; and close involvement by researchers in planning the programs they are evaluating.

These points are included in our current framework for evaluation drawn from the literature on mainstream modern evaluation. We use the tripartite division of evaluation into formative, process, and outcome evaluation. *Formative evaluation* ensures that the project is needed, well designed, and well implemented (Edwards 1987; Fitzpatrick 1988; McClintock 1986). Evaluation input is provided to program planning and decisionmaking on an ongoing basis through the collection and feeding back of relevant information to program personnel and management. This process includes needs assessment, review of previous literature, objective setting, pretesting of materials, and piloting. *Process evaluation* describes exactly what occurred in program planning, implementation, and running. It can take place on a small or large scale depending on the resources available and the need to communicate to others the details of what occurred during the program. It usually uses qualitative research methods (Patton 1990) but can use quantitative methods (McGraw et al. 1989). It provides a detailed description of what occurred during a program. It also assists interpreting outcome evaluation results by providing possible explanations for observed outcomes. *Outcome evaluation* attempts to measure whether the program objectives have been achieved. Outcome evaluation is the type of evaluation with which social scientists are most familiar and around which there has been a great deal of conceptual work in the past; for instance, with regard to quasi-experimental design (Cook and Campbell 1979).

Depending on the project being evaluated there is more or less emphasis on each of these three types of evaluation. In the CAP project there were formative, process, and outcome evaluations since it was a demonstration project and all these evaluations were essential. However, in the case of the Licensing Project, more emphasis was placed on formative and process evaluations rather than on the outcome evaluation for the following reasons.

First, there were already outcome data from CAP that supported the idea that, if well planned and well implemented, the alcohol worker community organization approach could be successful.

Second, because the new licensing mechanism was being introduced nationally, it was difficult to establish any reference areas that would be untouched by public health input. For instance, some of the public health input from local alcohol workers was directed at improving the sensitivity to public health issues of the national bodies involved in licensing. This activity affected the way the national bodies responded in all areas. Also, activity introduced by alcohol workers in one area was used as a precedent for the same approach in other areas, which makes it difficult for such other areas to function as references.

Third, even if there was some way of overcoming these difficulties, the political climate at the start of the Licensing Project was different from that at the start of CAP. There was support for a high level of funding for CAP because the main funding body was just starting out in its work in prevention. At the start of the Licensing Project the climate had changed and it was highly unlikely that a large-scale outcome evaluation of the Licensing Project could be funded.

While CAP was a demonstration project where the whole range of evaluation types could be used, the Licensing Project was undertaken in a context that restricted evaluation options. However, while opportunities for outcome evaluation may be limited in a case such as the Licensing Project, our experience has shown that a great deal of effective evaluation work can still be carried out in such projects in the formative and process evaluation areas.

Community

The use of community interventions has a long history (Dixon 1989). A "community" approach is now offered as a panacea for almost every conceivable social problem, usually with no reference to earlier experience with the method in other settings. However, as a concept community continues to remain tantalizingly vague. One author, after reviewing the community studies literature, identified 90 uses of the community approach; the only thing they had in common was that they all had something to do with "people" (cited in Rose 1990).

In order to clarify what is meant by community action in the context in which we work, health promotion researchers have drawn from the general literature on community approaches. For instance, Wakefield and Wilson (1986) have discussed Rothman's three-way division of community strategies into locality development, social planning, and social action, and Labonte (1989) has compared major styles of community development such as Alinsky's method with that of Freire.

We have yet to find a characterization of community intervention that captures all aspects of the method used in CAP and the Licensing Project. What we attempt to do here is spell out the features of our approach so that they can be compared and contrasted with approaches being adopted in other community alcohol problem prevention programs.

We have identified the following key features in the approach used in CAP and the Licensing Project.

Uses as its starting point research findings about alcohol-related problems and the strategies that are most likely to reduce those problems

Rather than starting with community perceptions, this approach has as its basis the research literature that has examined alcohol-related problems and evaluated strategies to reduce those problems. It promotes those strategies that, on the basis of present knowledge and the balance of probabilities, are most likely to be effective in reducing alcohol-related problems. So, for instance, the strategies in CAP were chosen following a careful reading of the research literature developed over the years preceding CAP. From this reading it was concluded that mass media and other methods of intervention that aim to minimize alcohol-related problems should not focus exclusively on individual behavior (Wallack 1980; Holmila et al. 1980). Price, availability, and promotion emerged as major areas for activity. The emphasis in CAP was more on availability and promotion because the range of community strategies on the issue of price was believed to be more limited. It was also acknowledged that a consistent alcohol policy motivated by public health considerations needed the backing of a visible segment of informed people (Bonnie 1978).

The approach in the Licensing Project built on the methods of community organization developed in CAP and applied those methods to the implementation of alcohol licensing policies. At the time of planning the Licensing Project, the question of the way alcohol licensing policies are implemented was emerging as an important theme in the international literature on alcohol problem prevention (Speiglman and Goetz 1987; Gruenewald and Janes 1989).

Presumes that knowledge and attitudes about alcohol in the community are likely to have been shaped by alcohol advertising, the medical model of alcoholism, and media portrayal of alcohol-related problems

The community organization strategy does not give a privileged epistemological status to unexamined community views of alcohol problems or their solutions. Community views on alcohol are actively shaped by the alcohol industry through advertising and public relations, which are likely to distort the community's perception of the magnitude and nature of alcohol problems and potential solutions. The community has also inherited the disease model of alcoholism, which focuses attention on the individual with a problem rather than on social factors in the wider environment.

Enters into a dialogue with relevant members of the community

The findings from the research literature regarding the most useful methods of reducing alcohol-related problems act as a starting point for dialogue with a small number of community members who, if convinced of the research conclusions, will support the community organizers in their activity in the community. In both CAP and the Licensing Project the community organizers were accepted by professionals, such as the District Licensing Authority staff, because each group had specialized and valued knowledge.

Relies on the reservoir of concern about alcohol-related problems in the community for tacit (not necessarily active) support

Despite the influence of alcohol advertising, within most communities there is usually tacit support at a general level for doing something about alcohol problems. The specifics of what that something is may initially be different from the strategies supported by the research literature; for example, increased penalties rather than increased enforcement and speedier implementation of sanctions, school-based education rather than licensing changes. However, because the community organization strategy clearly attempts to do something about alcohol-related problems and can support its approach with research findings, it gets the tacit support of the community for its work.

Accepts that few members of the community may have time to devote to alcohol issues

The approach used in CAP and the Licensing Project does not have as one of its major objectives mobilizing large numbers of people around alcohol-related topics because in the settings where we are currently operating in New Zealand those community members who have skills in community activity are already under a great deal of pressure addressing other pressing community issues. It is not that these people do not support the community organization effort on alcohol, it is just that this support can only be moral rather than practical. If mass mobilization were possible, it would be good; however, it is not currently a realistic objective.

Operates in any forum it can to organize around alcohol issues

The approach is not limited to operating in any one forum. For instance, in the Licensing Project, one of the regional alcohol workers was able to establish good links with the National Licensing Authority and another forged good links with the Ministry of Transport head office. Both of these are national level bureaucracies. These activities cannot be described as grassroots strategies, but are useful within the approach we are using. We do not hold that public sector bureaucracy is in some way inherently opposed to the community; the bureaucracy is simply another domain in which to operate.

Is directed at putting in place long-term structures in the community that will reduce alcohol-related problems

The focus of this approach is to put in place long-term community structures that will reduce alcohol-related problems permanently. For instance, in both CAP and the Licensing Project considerable effort was put into encouraging local governments to adopt policies on alcohol, which included their own use of alcohol, use of alcohol on local government-owned land such as sports grounds, and, in the case of the Licensing Project, a policy on the local government role and perspective on licensing issues. The idea is to create policies that will have an ongoing influence on the way in which alcohol is dealt with in that community in contrast to just running short-term campaigns on alcohol abuse. Such activities include identifying funding options for community-based workers, which increases the likelihood of their ongoing involvement.

These seven points isolate key features of our approach to community intervention as it has currently evolved. Our approach does not fit nicely into one of the currently available models of community intervention. It is an approach that has developed in our particular context, and the extent to which it can be generalized needs to be debated. We offer this brief description so that our approach may be compared and contrasted with approaches being adopted elsewhere.

Future of Research on Community Strategies

We would like to conclude by commenting on the wider issue of the most fruitful directions for future research on community strategies for reducing alcohol and other drug problems. Panzetta (1971), from the community mental health area that was down the community intervention road several decades before us, warns that looking for "community" can turn into something of a search for the Holy Grail:

What seems a rational premise is that the search for the "community" be abandoned. A search for the Grail would be as rewarding. What then should a mental health centre set about to do vis-à-vis its "community"? Contrary to the romantic readiness to do the community will, a mental health centre must know, in advance, what it is it can do and wishes to do. Armed with this sense of identity and purpose, it can turn to "its community" and identify itself. As part of its process of deciding what it is and what it can and wishes to do, it must also decide to what degree it wishes to balance its internal decision making processes by the inclusion of persons *identifiable* as (a) area residents; (b) vitally interested in the work of the centre; (c) with the ability to conceptualise the types of problems and types of solutions involved; (d) with a willingness to participate and an ability to disagree as well as agree. (p. 296)

The situation is even more complex in the field of community action to prevent alcohol-related problems because the nature of the interaction between research and program development is also affected by the basic politics of the alcohol problem prevention field. These politics mean that the most important factors in determining which prevention strategies are actually implemented are their political acceptability, public relations profile, and cost. From our experience we find that whether such projects are effective or not is a minor consideration. If a project's effectiveness may mean reduced alcohol consumption, then it is likely to be actively resisted by those who have a financial interest in maintaining consumption. Given this political climate it is likely that much energy over the next few years will be poured into community approaches that conform to models that are the most politically acceptable and have the highest public relations profile.

In addition to the political pressures for certain types of community programs, there is the problem of the sheer bulk of possible research topics in the community intervention area. For instance, the papers from the Office for Substance Abuse Prevention 1989 Symposium on Experiences with Community Action Projects contain many possible research avenues that could be explored—particularly since the differences between communities can be used to argue that each issue may need to be examined in each community. Examples of the topics are building formal models of communities, which describe a wide range of features related to the use of alcohol (Holder and Giesbrecht 1990); exploring the six dilemmas of democracy and community action programs (Larsson 1990); and undertaking more theory-driven research using systems theory, social network theory, and social change theories and drawing on the disciplines of political science, public health, sociology, anthropology, and psychology (Report of Workshop 1 1990).

Obviously, all these issues and approaches need to be researched to some extent, and different research groups will be able to investigate them to a greater or lesser degree. However, in New Zealand the alcohol and other drug prevention research community is relatively small. Every piece of research we undertake has an opportunity cost associated with it in the form of other research that we do not have the time or resources to do. We do not have the luxury of exploring the myriad aspects of community that will arise in the course of our work in this area. Now is the time when we need to be particularly strategic about the topics we research. Which topics are the most relevant to a particular research group depend on the particular situation in which they are working and cannot be prescribed from outside. However, as a guiding principle, we believe that we need to assess all our research enterprises from the pragmatic perspective of how they relate to the implementation of practical projects in the community, rather than how they relate to the construction of a theoretical edifice around the issue of community interventions. We are well aware of the difficulty of keeping such a pragmatic focus.

However, we can start by being willing to question each other openly about the relevance of our research topics to practical action.

Acknowledgments

The research on which this paper is based was funded by the Alcoholic Liquor Advisory Council of New Zealand and the Health Research Council of New Zealand. We would like to acknowledge the major contribution of the alcohol health promotion workers and the supportive members of their communities in the development of this approach to community organization to reduce alcohol-related problems.

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Methodological Issues in Community-Based Alcohol-Related Injury Prevention Projects: Attribution of Program Effects

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The Rhode Island Community Alcohol Abuse/Injury Prevention Project (RI CAAIPP) began in October 1984 through a cooperative agreement among the Centers for Disease Control (CDC), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Rhode Island Department of Health (CDC-NIAAA Cooperative Agreement No. U50/CU100832 and NIAAA R01 AA08277). It was fundamentally an epidemiologic research project with a prevention intervention component. Project goals were defined by the original request for applications and included establishing a model or demonstration project to conduct an in-depth epidemiologic study of selected risk factors for adverse health-related outcomes of alcohol use in each of two communities in a State. High-problem groups and locales were to be profiled, and a quasi-experimental study was to be conducted to evaluate the impact of an intervention program to reduce or prevent alcohol-related health problems in one of the two communities. The actual project involved one intervention community and two comparison communities in Rhode Island.

The alcohol-related health outcomes to be influenced were confined to injuries, as acute conditions amenable to rapid prevention. Assault injuries and motor vehicle crash injuries were selected as target health problems since both are highly alcohol related and subject to community mobilization of response, involving, as they may, nondrinking third parties in the injury events.

Data and Methods

Twelve data sets were developed, tested, refined, and implemented for baseline and followup data collection of the three communities before one was selected as the "intervention" site. These data sources fall into two main categories—surveillance data sets and survey data sets. The data were collected uniformly by community. Surveillance data, continually collected for residents by project staff over the study period, included data on all resident police arrests and motor vehicle crashes with police presence. A hospital emergency room (ER) surveillance system was instituted using a 12-percent sample of cases. All ER visits of residents 14 years of age and older were abstracted for 44 sample days each year. The regular sample of 25 days per year included every 15th day after a random start in 1985 (with substitutions for holidays). The weekend oversample of 13 days per year added extra Fridays, Saturdays, and Sundays; six holidays were included each year (New Year's Day, St. Patrick's Day, Memorial Day, July Fourth, Thanksgiving, and Christmas). The ER data oversampled weekends and

holidays to maximize the yield of alcohol-related events. Data were collected from four hospitals in three communities over 3 years; 2 more years of data are expected, but not yet available from the project. A total of 14,455 ER visits were sampled over the 3 available years and the three sites. None of these data could be obtained from published sources because they needed to contain information on alcohol involvement, to be based on residents of each of the three communities, and to be disaggregated for analytic purposes (Putnam 1990).

Matching provided the basis for selecting the project communities. This matching followed extensive comparisons of sociodemographic and health status variables and alcohol-related problem indicators. Because the two comparison sites in combination matched the intervention site on a range of background variables, their joint selection was seen as providing the best control for program effects. Thus, for example, the intervention community and comparison site 2 share characteristics with respect to their level of industry and employment, age and fertility of the population, and community stability, while the intervention community and comparison site 1 match on some economic indicators, such as percentage of poor and percentage of families at the poverty level, and they have similar-sized police departments. Comparison site 2 and the intervention site share similar alcohol-related death rates, while similar injury death rates are observed across all three communities. Age-adjusted mortality rates are also comparable for all three. Motor vehicle crashes are more prevalent as a cause of death in comparison site 2 and the intervention site, reflecting the fact that half the respective residents work outside their communities compared with 27 percent of comparison site 1 residents. Residents of all three communities are highly likely to be hospitalized locally, suggesting that medical records data on resident ER visits yield high proportions of community residents.

Community Interventions

After 18 months of baseline data collection, one of the three communities was selected at random as the intervention site and the remaining two served jointly as the control. Intervention strategies were designed to reduce injury morbidity and mortality, the incidence of intoxication, and the likelihood of combining drinking alcoholic beverages with driving and other high-risk behaviors. Strategies included socio-cultural environmental modification affecting group norms and behavior; regulatory mechanisms in the form of increased law enforcement and mandated penalties; education and information as a primary method of persuasion; and economic incentives and disincentives through the use of dram shop legal liability as a lever for server training and responsibility. Community interventions selected to influence the system included police training and technical assistance, responsible sales and service training and policy adoption among alcoholic beverage establishments, and community mobilization efforts through mass media and publicity campaigns, local task force activities, and community forums. Planned, but not imple-

mented due to lack of resources, were worksite employee assistance programs and hospital and ER training programs (Putnam 1990).

This integrated approach to reducing alcohol-related injury morbidity and mortality (Wallack 1984–85; Yates and Hebblethwaite 1983; Holder and Wallack 1986) was instituted in the intervention site immediately after its selection in June 1986. Sobriety checkpoints, police training and technical assistance, and community mobilization started in September 1986. Server training began in March 1987, and police radar patrols in June 1987. These and other efforts continued through 1988.

The injury prevention programs were based on the assumption that two community gatekeeper groups—the police and servers of alcoholic beverages—occupy the front line of injury prevention (Harrington et al. 1989). Resources and skills training were offered through the project in an effort to effect positive changes in the knowledge, attitudes, and practices of police officers and servers relative to their legal responsibility regarding intoxicated citizens or patrons and drunken drivers. Increased enforcement of DWI (driving while intoxicated) laws and other liquor laws by police and more responsible sales and service of alcoholic beverages by liquor licensees were expected to reduce excessive or inappropriate drinking in high-risk situations and other high-risk drinking practices. These practices, in turn, would decrease alcohol-related problems, particularly injury morbidity and mortality.

Server Interventions

The central elements of the server intervention programs were written responsible service policy adoption among alcoholic beverage licensees, and a 5-hour training program for servers on dram shop liability laws and techniques for identifying intoxicated patrons, refusing service, and preventing intoxication. The basis was the National Highway Traffic Safety Administration (NHTSA) model curriculum, now offered by the National Safety Council as the ASK (Alcohol Servers' Knowledge) program. City council workshops featured project-sponsored training of city counselors on criteria for enforcing local liquor ordinances. As of December 31, 1988, 100 percent of off-premise and 79 percent of on-premise establishments had adopted written policies for responsible alcoholic beverage service. Three hundred ninety-two (61 percent) of the estimated 640 professional servers employed in 97 licensed establishments had been trained by project staff. Of these, 39 percent were servers in bars, 26 percent in restaurants, and 22 percent in private clubs, and 13 percent were package store employees. The most difficult groups to reach were owners, managers, and employees of private clubs, small neighborhood bars and lounges, and economically marginal establishments. Easier to reach and more amenable to program adoption and successful implementation were owners, managers, and staff of larger restaurants and package stores (Putnam 1990).

Police Interventions

Police enforcement and training programs were aimed at increasing enforcement of DWI laws, especially at lowering blood alcohol concentrations (BACs of .10 to .15 mg/dL); increasing enforcement of local and State liquor laws; improving knowledge by police officers of dram shop laws and the role of alcohol in crime; and improving reporting of alcohol involvement in non-DWI arrests. Project-sponsored activities included radar patrols at selected intersections designated as high risk for speeding-related motor vehicle crashes; NHTSA-funded sobriety checkpoints or roadblocks for DWI enforcement; and selective enforcement of dram shop laws in local bars, restaurants, and package stores by plain clothes detectives. The project provided equipment to the police needed to supplement their increased enforcement activities, including a second breath test machine, an Intoxilyzer 5000 (Federal Signal Corp., Minturn, CO), and a simulator; checkpoint cones and barrels; passive alcohol sensors as nonevidentiary field breath testers; and a video camcorder for filming trainings, roadblocks, and patrols. Police training programs included NHTSA training in Improved Sobriety Testing (gaze nystagmus); training on the role of alcohol in police work; training on police liability in dealing with intoxicated citizens; training of one patrol officer in on-scene crash investigation at Northwestern Traffic Institute, a precedent for the department; and training in the use of CAAIPP-sponsored subjective alcohol report forms (Putnam 1990).

Study Challenges

Some preliminary results from the Rhode Island study are presented here to help illustrate certain methodological and analytical issues emerging from such studies. These issues involve questions of attribution of observed changes as program effects, the importance of treating data sources as a systemic whole, problems of interpretation of alcohol relationship attributable to data deficiencies, and insufficient time points for proper time-series analysis.

Two challenges in the data collection included the need to confine it to residents of each of the three study communities for the development of accurate rates, and the paucity and presumed inaccuracy of data on the presence and role of alcohol in the events under study. A special examination of alcohol reporting in various data sets suggests that police arrest records and medical examiners' (ME) data contain the most, and perhaps the best, reporting of the role of alcohol in events. Such information is evidentiary and, in the ME cases, toxicological tests are often routine because informed consent is no issue. On the basis of records data alone, 44 percent of arrests were found to be alcohol related, and 64 percent of ME cases were reported as alcohol related. Two-thirds of injury deaths were alcohol related in contrast to one-third of noninjury deaths. Death certificate data fare the worst (1 percent of deaths were reported as alcohol related in the three communities), followed by motor vehicle crash data (5 percent) and ER records (6 percent). It is clear that

underreporting of the role of alcohol in such events is a major problem in studies of intervention program effects.

In response to the reporting problems, expensive primary data collection using police and ER systems and attempts to institute objective testing or screening for alcohol in police and ER events were initiated. Objective alcohol testing was stymied by the problem of arrestees being captives and unable to give informed consent for alcohol testing, and the resistance of ER staff to a routine testing procedure that might jeopardize their return clientele and that was not seen as clinically indicated. The only success in this regard was the addition of a subjective alcohol report form in all three police departments to collect more accurate and complete data over a 6-month period in 1986. While the subjective forms nearly doubled the reporting of the presence of alcohol in nondrunken driving arrests (from 36 percent to 62 percent alcohol-related), the intervention community police used the forms more frequently and for a longer duration than police in comparison sites, which is attributed to the Hawthorne effect.

Because of the uneven and dubious quality of the data on alcohol in police and ER report forms, records audits make it difficult to determine whether intervention programs reduced alcohol-related outcomes in contrast to non-alcohol-related outcomes of interest. This flaw is in all studies and represents a serious confounder in interpreting results and measuring program impact. This problem will be illustrated here. The problem of seasonal variations or fluctuations in event occurrence as a confounder will be addressed when the last 2 years of ER surveillance data from the Rhode Island project (for 1988 and 1989) become available. The 3 years of data that are accessible (1985, 1986, and 1987) contain too few data points to conduct such a time-series analysis.

Results

The question of interest here is whether the intervention site experienced any changes in alcohol-related injury reporting and/or incidence as measured by the ER surveillance system, and, if so, were the changes observed in comparison site ERs as well? Is the intervention program showing the expected effect on injury rates, especially rates of assaults and motor vehicle crashes; are the effects attributable to interventions, and, if so, what may explain or confound the effects?

Two data sets (police arrest and ER data sets) will be examined and some preliminary conclusions and recommendations will be made. The objective here is to pinpoint some of the problems and concerns with data interpretation in this type of study, as well as to share tentative and preliminary study results. Definitions of alcohol-related events in the two data sets are available on request, along with the relative prevalence of their constituent characteristics

at baseline. In police arrest data, officers' mention of alcohol use or intoxication accounted for 86 percent of alcohol-related arrests. Other frequently reported indicators of alcohol relationship were alcohol noted on breath, location at a liquor-licensed establishment, conduct of a sobriety test for a DWI arrest, and the arresting officer's report of alcoholic beverages on the scene. Similarly, 96 percent of ER visits judged to be alcohol related involved mention by health care providers of alcohol use or intoxication in the ER record, followed by taking a BAC or finding a positive BAC, and by assignment of an alcohol-related diagnostic code (International Classification of Diseases, ninth edition). In 16 percent of alcohol-related ER visits, a referral for detoxification was made.

First, arrest rates increased in the intervention site in contrast to comparison sites, for which data are combined for ease of presentation. Overall arrest rates increased by 9 percent, alcohol-related arrest rates by 11 percent, and DWI arrest rates by 4 percent. Alcohol-related assault arrest rates increased as well—by 27 percent. All comparable arrest rates in comparison sites decreased between 10 percent and 29 percent. It is notable that assault arrest rates, on the other hand, remained stable in the intervention site, while there was a small (7 percent) increase in comparison sites. Thus, in the intervention site assaults may have been occurring less frequently, while police were getting better at identifying and reporting alcohol-related assault arrests among the assault cases.

ER injury visit rates declined by 9 percent in the intervention site between 1986 and 1987, compared with virtually no change for comparison sites. This decline is especially dramatic for assault injury rates: the intervention site had a 21-percent drop compared with a 4-percent increase for comparison communities. Motor vehicle crash injury visit rates showed a 10-percent decline in the intervention site from 1986 to 1987 compared with a 12-percent increase for the comparison sites. Head injury visit rates also decreased dramatically in the intervention site (by 24 percent) compared with rates at comparison sites, where they essentially remained level (a 3-percent decline). The fact that the rate of injuries with loss of consciousness remained stable across time in the intervention community suggests that the less severe head injuries may be more likely to have declined than the much rarer, more severe head injuries.

These declines in ER visit rates for injury contrast not only with increases in police arrest rates (with the single exception of assault arrest rates), but also with overall ER visit rates and those for noninjuries. Noninjury cases are identified as diagnoses coded using ICD-9 diagnostic codes other than those for injury (primarily in the range of 800-999) with no accompanying external cause codes (E-codes); the latter codes were used by project data abstractors for all injury cases. Overall, ER visit rates did not change in the intervention site over the period, while they increased slightly (by 7 percent) in comparison sites. Noninjury visit rates increased in both intervention and comparison

sites (by 6 percent and 24 percent, respectively). Alcohol-related ER visit rates manifested little evidence of change (a 4-percent increase in intervention site and a 1-percent increase in comparison sites). This result was expected given no improvement in alcohol reporting and no ER-specific or targeted intervention or training programs to enhance case finding.

Conclusions

First, increases in intervention community arrest rates are attributable to increased police enforcement, partially program sponsored, and may be a program effect. They may also be due to better crime reporting, a greater propensity on the part of police to make arrests, and increased crime incidence. Second, decreases in intervention community ER injury rates, especially assault and motor vehicle crash injury rates, along with decreased head injury visit rates, are probable program effects. They were hypothesized and targeted. However, this conclusion requires confirmation and elaboration, using additional ER data and community survey results at followup.

In support of program attribution of these effects are the facts that decreases are observed only for injury-related ER visit rates, not for total ER visit rates, noninjury visit rates, or alcohol-related visit rates, and decreases are observed only for intervention hospitals. The possibility that declines in injury rates based on these ER data are due to transfer of major trauma cases to the regional trauma center at Rhode Island Hospital must be considered. However, the declines noted in less severe head injuries (those not associated with loss of consciousness) suggest that such an explanation, if feasible, is partial and requires further empirical support.

Primary and secondary prevention related to server training and police training, technical assistance, and enforcement programs is therefore possible, and even likely. Coupled with these injury reductions are process evaluation results showing significant improvement in server knowledge from initial training as well as in behavior change scores for responsible server practices in general when dealing with young patrons, especially minors, and in practices designed to detect and reduce the early effects of drinking before the patron becomes intoxicated. These changes were observed between the pretest (1987) and the first posttest (1989) periods based on self-reported frequency of certain server practices (Campbell et al. 1991).

Recommendations

Since these data represent a system, attribution of program effects by "triangulation" is necessary. For example, the RI CAAIPP three-community baseline and followup survey of adults could be examined for changes in self-reported alcohol consumption, alcohol-related problems, drinking norms and practices, and injury and other health experience related to ER surveillance data sets. Changes over time in the intervention site would be compared with

changes in the same variables from baseline to followup in the comparison sites. This source would provide other evidence to support or refute the above-noted declines.

To confirm program effects and to pinpoint the changing role of alcohol in injury events, wherever possible, time-series trend analysis should be conducted to relate programmatic milestones to changes in injury visit rates, controlling for seasonal and other extraneous effects. Long-term program studies should be funded in the alcohol-injury field because a minimum of 30 data points representing about 7 years (if quarters are the time intervals used) are needed for such analyses.

Given ER data for the Rhode Island study for 1988 and 1989, tests of the suggested program effects include a look at their persistence and sustainability. The decrease in injury rates should have persisted for the duration of the program (officially through 1988). At the end of the program, if community ownership had not occurred, injury rates should have returned to preintervention levels or moved toward levels of comparison sites. Such analyses await data access.

Because alcohol involvement in injury is not a reportable condition, and because alcohol abuse is potentially stigmatizing and legally problematic, data from existing hospital, police, and death records underreport alcohol involvement in injury events. Efforts to increase case finding through improved reporting are subject to complicated informed consent requirements for human subjects' protection and a consequent loss of respondents, which biases study results. Nevertheless, early and continuing efforts should be made to institute routine clinical screening in ERs for alcohol as well as other drugs. These efforts include training and technical assistance of ER staff in the use of external cause injury codes from ICD-9 and ICD-10, and access to and/or help in creating computerized ER logs and other records to save on both time and cost in data collection. Such screening for alcohol is also needed in police departments.

It is important to say that insofar as responsible alcoholic beverage sales and service training and policy adoption coupled with police training and enforcement programs function to reduce injury, they are expected to avert injuries immediately with no time lag; because these conditions are acute and have a short preclinical phase. Therefore, injury surveillance and prevention are essential to community-based alcohol and other drug intervention programs and studies. They provide the major, sometimes the only, means of obtaining objective data on changes in levels and patterns of injury morbidity and mortality. More than changes in knowledge, attitudes, and practice related to alcohol consumption among drinkers themselves, reduction in intervention-related injury rates signals success in attaining the premier program goal of alleviating adverse health outcomes in a target population.

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Symposium Plenary Discussion

In response to outcome ambiguities reported by Sandra Putnam in the Rhode Island study, there was a discussion of various outcome measures that might have put a different slant on the evaluation. Tim Stockwell and Kathryn Stewart raised questions about nighttime motor vehicle crashes and the actual practices of alcohol servers as outcome measures, as opposed to outcomes mentioned in the study—arrest rates, ER cases, and server attitudes. Putnam replied that declines were noted in the Rhode Island project in "high-risk crashes" in the intervention community, those crashes being defined as single-vehicle, late-night, weekend crashes with young male drivers. She said a paper to be delivered by Robert L. Stout later in the symposium suggests that process evaluation of server training showed positive changes in server knowledge and

attitudes after the training. Putnam referred to difficulties in linking outcomes with program activities. Although it was evident that "something happened" in the community, it wasn't clear that those things were the result of program activities. Alex Wagenaar suggested that stratifying ER injury cases by the severity of injuries would help clarify program effects, because in many communities there are now "urgent care" centers for less serious injuries that once would have been treated in hospital ERs. Putnam said the fact that head injury rates declined at the intervention site, while rates of loss of consciousness remained the same, suggests that it is the less severe head injuries that were reduced. This argues against diversion of injury cases to a large trauma center as an explanation for ER injury rate declines, she said.

Wagenaar continued with an observation about Louis Gliksman's reference to the "readiness of communities" for various interventions. "What kind of indices do we use for readiness?" he asked. On the same note, Norman Giesbrecht asked about the positive and negative implications of the activities that Gliksman described. "It seemed to be dumping large quantities of money into a community and then sitting back and saying let's see what they do with it."

Gliksman said his group did indeed pick communities that appeared to be more ready for intervention than others. The choices, he said, were subjective, and based on criteria that the researchers had established. "What we were looking for in terms of readiness was that they should have some sort of infrastructure—coalitions that had been formed...a history of having done things in the past." This criterion meant the money went into communities that at least had done something in the past. Also, the money went into economically deprived communities and, therefore, provided some jobs, recreational activities, and venues for segments of the population to get together. "In the very broad sense," Gliksman said, "it may have begun to create more of a sense of community than existed before. Whether that sense of community will be maintained once the money is gone becomes a moot point." He pointed out that one of the goals of the sponsoring agency was to create a sense of empowerment in the communities.

Jan Howard said she is interested in setting up some kind of "rapid response" system at NIAAA that could respond to requests from States or communities to evaluate programs that were not necessarily of the researchers' choosing. "We might have some impact on their fine-tuning or even on their demolition if they don't work," she said. Gliksman commented that he was frustrated by being in a situation where he had to cede control over the selection of participating communities to the sponsoring agency and become "totally reactive." Gliksman and Howard agreed, however, that the directives of the sponsors forced the researchers to be "creative."

Robin Room said his recent move from one research group to another had reminded him that the way research is funded plays a major role in the

formation of projects. In the environment created by NIAAA grants, he said, data collection is what justifies the whole project and the outcome evaluation is of primary importance. "There is a lot of formative process that goes on even in those kinds of studies because the first person who asks the question, what's going to happen here, what exactly are you going to do, is the evaluator." The opposite model is one where "the researchers basically have a job to do and then scrounge around to find extra money to do any outcome evaluation." What tends to happen in outcome-driven projects, he said, is that the documenting of the process seems to get lost along the way. The point is that the formative process should not be neglected in these large outcome-driven projects.

Paul Duignan observed that formative and process evaluations were as much science as outcome evaluation, prompting Putnam to point out that the Rhode Island project did do process evaluation but she had not reported on it; it was not the primary focus. "Politicians like outcomes," she continued. A favorable outcome is what sells a program.

Shireen Mathrani recalled Gliksman's reference to the future when the money for the Canadian project "dries up" and asked whether the Canadian program would continue after the initial funding ends. Gliksman said the communities in the study are beginning to ask whether there will be more money available. "They're looking for more money from the same government sources, as opposed to looking for alternate sources," he said. Sally Caswell noted that, in her experience, community leaders want to know whether a particular approach is useful and effective, and therefore process evaluation is important for encouraging a sustained effort.

Fried Wittman asked Duignan to elaborate on his reference to the importance of starting from a research base in organizing a project. He said he would agree that formative evaluation is important as an early element to legitimate the presence of researchers in developing the project. But this leads to the question of how the researcher handles any discrepancies between what he thinks is right and any misconceptions or preconceptions in what people in the community are thinking. How do you evaluate the quality of the community's knowledge? Duignan said there is an effort to start with no preconceived notions or assumptions, and to reach formative decisions through negotiation and compromise. However, researchers must give community organizers certain assumptions on which to base a discussion. Researchers have to take something to the community, he said. It would be irresponsible for them to say "we know nothing." Tom Greenfield commented that this discussion seemed relevant to the current disarray in the community mental health movement in the United States and its failure to reach the population it is supposed to be serving, a consequence of being services centered rather than client centered in its approaches. "Somehow we have to find a way to allow something to be generic, filled in with ownership by the grassroots, and with the field contributing some intelligence to it also."

In response to a question from Rhonda Jones, Duignan said researchers can put things into the social structure of a community that will remain after they leave the scene. If empowerment takes place, the community would not need researchers in the future.

CHAPTER 2

Policy Adoption Case Studies

Licensed Drinking Establishments/ Antidrink and Driving Campaigns

Structuring Drinking Environments To Promote Moderation: The Balance Between Research and Social Interests in Policy Development

Diane McKenzie

Introduction

On September 15, 1990, the government of Ontario enacted an all-new Liquor Licence Act following a lengthy review of Provincial alcohol regulations. This review began in 1986 with the appointment of a special committee whose mandate was to sweep away outdated restrictions and modernize rules and regulations governing the on-premise sale of alcohol. This paper chronicles that review process. Specifically, the roles of public perceptions, various interest groups, and policy research within the policy development process are examined. Conceptual and empirical problems associated with the application of research to policy debates are discussed.

Background

The Ontario Advisory Committee on Liquor Regulation was chaired by the parliamentary assistant to the minister of consumer and commercial relations and comprised the board members of the Liquor Licence Board (LLBO), a representative from the Liquor Control Board (LCBO), and a special advisor from the Addiction Research Foundation (ARF). The advisory committee was under mandate to review: (1) the general philosophy and values to be entrenched in the Liquor Licence Act and reflected by the regulations; (2) the type and nature of licenses issued; (3) the criteria used to assess applications; (4) the days and hours of operation of licensed premises; (5) the legal drinking age of 19 years; and (6) the content and regulation of alcohol advertising.

The review process involved three phases of activity. First, background information was collected and written comments were solicited on these issues from licensees, municipalities, other Provincial ministries, and special interest

groups. Second, a series of public hearings were held throughout the Province. Submissions were received from a range of interest groups such as licensees, hospitality associations, beverage alcohol producers, student groups, public health agencies, citizen groups, municipalities, religious organizations, police agencies, and private individuals. The final stage involved analysis of the submissions and preparation of recommendations.

There were six primary considerations to account for in formulating the new law: (1) access to liquor for the enjoyment of responsible drinking; (2) the economic interests of the hospitality industry; (3) the right of the employees in the hospitality industry to earn a living; (4) the right of their neighbors to quiet enjoyment of their properties; (5) the prevention of problems related to alcohol abuse; and (6) maintenance of public order and public health.

Overview of Recommendations

The recommendations made by the advisory committee for the new Liquor Licence Act and its regulations increased the ability of the government to control alcohol and opened the door to more responsible server practices. Although several changes involved a relaxation of controls over on-premise consumption, these liberalizations have been offset by tighter controls in many other aspects of regulation.

License Classification

A major reclassification of licenses was recommended. A general license to sell alcohol replaced 12 different classes of licenses. Under this new license, food must be available at all licensed establishments at all times. Beverage alcohol delivery services are licensed, and alcohol producers are permitted to own two establishments to promote their products. Stadium licenses are subject to stringent security measures and require alcohol-free sections in order to give a reasonable choice of seats to those who prefer sitting in a nondrinking area.

Special Occasion Permits

Special functions represent a major source of drinking problems in Ontario. These events are difficult to control, particularly in terms of the overservice of alcohol, service to minors, and unfair competition with licensed establishments, which are subject to more regulation. Under the new Liquor Licence Act, banquet halls and catering services can be licensed to provide alcohol for special functions. Server training is mandatory for holders of catering licenses. The LLBO now has the authority to refuse a special occasion permit license to an applicant with a history of violations.

Days and Hours of Operation

At the beginning of the legislative review, all licensed establishments could operate between 11 a.m. and 1 a.m., Monday through Saturday, and dining licenses could operate on Sundays between noon and 11 p.m. The hospitality industry lobbied strongly for longer operating hours and Sunday sales. Competition with border areas where neighboring jurisdictions have late closing times and public demand for extended hours were the arguments posed by the industry. However, fears of increased drinking and driving led the committee to recommend a modest increase in hours of operation from 10 a.m. to 2 a.m. The measure did not survive cabinet review. Maximum hours of sale in licensed establishments remained the same as before, although Sunday closing has been extended by 2 hours.

Drinking Age

The most salient issue was that of the drinking age. Public health agencies and citizen groups argued for raising the drinking age on the grounds that this would reduce drinking and driving accidents by underage drivers. Student groups and the hospitality industry lobbied against raising the drinking age on the basis that a higher drinking age discriminated against nondriving and responsible youth. Although the drinking age remained the same, one change was made to assist enforcement of the age laws. It is now illegal to permit underage drinking on licensed premises. Under the former legislation it was illegal to knowingly sell or supply alcohol to minors. This change places a greater onus on licensees to ensure that alcohol purchased by an adult patron is not passed along to an underage patron and that a minor does not provide false age documentation.

Advertising

Another issue that received a great deal of attention during the public hearings was advertising. Particular concern was raised about the increase in "lifestyle" advertising. More stringent requirements on the content of advertising, with specific prohibitions against appeals to youth and the association of alcohol with activities requiring care, skill, or physical danger, were recommended. Guidelines have been drafted but they have not been put into the regulations, and they are currently under further review by the government. It was also recommended that a significant portion (10 percent) of advertising budgets be spent on public service messages warning the public about the hazards of alcohol consumption. This measure has already gone into effect.

Civil Liability

A wide range of issues were considered concerning the civil liability of persons who provide alcohol to others for the damages and injuries caused by intoxicated persons. The advisory committee proposed that the current statutory provision of

liability be replaced by a comprehensive fault-based approach that is consistent with other types of negligence actions. A server's liability will be restricted to situations in which he or she knowingly or negligently serves a minor or serves a person past the point of intoxication (.08 mg/dL blood alcohol concentration [BAC]). Tavern owners would be liable for damages caused by underage or intoxicated patrons but they would also be provided with guidelines and reasonable standards of conduct that would give responsible operators some measure of protection. A tavern owner who monitored his or her door, ensured the staff was trained in responsible beverage service, and had house policies aimed at preventing intoxication could argue that everything possible was done to prevent an intoxicated person from being served. As yet, these provisions have not been adopted into law.

Education and Server Training

The advisory committee recommended that all servers in the Province be required to take a training program as a condition of employment in the hospitality industry. Course content and standards would be developed by the LLBO in collaboration with ARF and hospitality interests. The cabinet approved this recommendation and LLBO is currently developing an implementation plan in conjunction with ARF. Mandatory server training was implemented for all licensed stadiums in the Province in 1989 and all holders of catering licenses in fall 1990.

Other Issues

The cabinet took other significant initiatives that promote more responsible use of alcohol. First, licensees are now held responsible for illicit drug use on their premises. Up to now, LLBO had limited power to impose sanctions on licensed establishments that allowed or ignored the use or sale of illicit drugs. Second, the forum for appeals of LLBO decisions will be the Divisional Court rather than the Commercial Registration Appeal Tribunal. The Divisional Court will be less likely to reduce penalties that LLBO imposes on licensees who violate regulations. Third, price discounting (such as happy hour) or any pricing practice that encourages immoderate consumption is now restricted. Finally, the definition of manufacturer under the Act has been expanded to include foreign manufacturers and their agents. Now all manufacturers of liquor who sell their products in Ontario will be subject to the same advertising and promotion restrictions as domestic manufacturers.

Although the advisory committee took less than 6 months to complete its work, the government approval process took another 3-1/2 years to reach a consensus on liquor law reform. This lengthy process was due, in part, to the need to achieve consensus on the new law among the key players in the cabinet. The ministries of Consumer and Commercial Relations, Industry and

Trade, Health, and Tourism, and the Attorney General and Solicitor General are affected by the Liquor Licence Act. Other factors such as a change in ministers and related support staff, which required that several issues be reworked, and translation of policy options into legislation contributed to this lengthy process. A lack of research assessing the impact of many policy options (e.g., extended hours) meant that public perception played a major role in determining the final recommendations to the cabinet.

The Role of Research in the Policy Formulation Process

Many factors contributed to the formulation of policy options. Although the initial intent of the review of liquor licensing was to bring drinking regulation "into the 20th century," public concerns about liberalization led to a more cautious approach to reform than was expected. The economic interests of licensees, the hospitality industry, and beverage alcohol producers and their employees were considered throughout the policy formulation process, as were those of student, citizen, and religious groups. Throughout the process, policymakers sought the middle ground on contentious issues in order to satisfy the interests of all the relevant actors in the policy debate.

Research contributed surprisingly little to the substantive content of the policies that were ultimately adopted. However, it filled several critical roles that helped shape the final product in important ways. First, background epidemiological research influenced the advisory committee to adopt an underlying philosophy of social responsibility, prevention, and control. The advisory committee took the position that access to alcohol is a "limited" right. The limitation of individual rights was justified on the grounds that the consumption of alcohol represents a major problem to society. The board committed itself to "regulate the service and consumption of alcohol in a manner consistent with the promotion of moderation and responsibility" (Advisory Committee on Liquor Regulation 1987). This approach was consistently applied across the policy formulation process. In addition, research placed boundaries around some policy options (e.g., drinking age) and served as a "test of consequences" for others (e.g., hours of sale).

The main contribution of research to the policy formulation process was to provide a conceptual framework for decisionmakers who developed policy options; research provided little basis for the content of policy options. An "expert adviser" on the committee provided a conceptual interface between research and decisionmaking. His job was to communicate and interpret research findings to decisionmakers and provide guidance in applying these principles to policy issues. The decisionmaker's new and improved knowledge about the special problems posed to society by the sale of alcohol for public consumption framed political values that were reflected within the act. These values determined the form of specific policy options throughout the formulation process.

Empirical Constraints to Direct Policy Input

It is difficult to say why research didn't have a more direct role in policy formulation. On the other hand, perhaps the division between research and policy is appropriate. Traditional research cannot provide guidance for developing specific policy options because it is not structured to address issues of direct interest to decisionmakers. Researchers examine questions from a field of study rather than from practical matters of government. Concern for scientific accuracy, traditional approaches to design, and the progressive development of knowledge are strong impediments to conducting responsive policy research. Researchers frame their questions around methodologies in which they are trained; they tend to examine factors that are beyond the control of decisionmakers while factors that are open to manipulation by government are ignored. Moreover, researchers often recommend policy approaches that conflict with the values or power structures of society at large. This situation places public health research outside the policy arena. Decisionmakers need recommendations that are consistent with directions for action.

Another problem that limits the role of research in policy is that research results are equivocal: research findings vary widely on similar issues. One reason for this situation is that policy research as a field of inquiry is relatively new. Many methodological issues remain to be resolved before strong and consistent policy evaluation can be done.

Conceptual Issues

Policymakers confront a highly political world. As a result, they focus on issues that arise from public concerns and that must account for many conflicting points of view. Public health represents only one of many diverse views that are considered within the policy formulation process. Action-oriented researchers must be aware of this situation in order to develop alternative strategies that will help them gain more influence in policy debates.

Effectiveness in policy debates requires the ability to offer specialized knowledge and keep it well grounded in a broad perspective that takes political, economic, cultural, and historical factors into account. The experience of the Ontario Advisory Committee on Liquor Regulation shows that government places high value on achieving consensus among interest groups and government ministries when developing policy positions. Policy submissions and advice papers must recognize the broad range of factors that affect policy issues in order to be acceptable to government. Public health must accept the terms of real-world policy formulation and adopt strategies that help us work within this complex decisionmaking environment.

What can action researchers do to gain more influence within the policy arena? An area of policy evaluation known as the "sociology of knowledge application" may provide some important answers. Utilization patterns of

policy evaluations indicate that the production of relevant information and its effective communication to a single individual within government are the key factors that lead to the use of research in policy. A decisionmaker must be committed to research and its application to policy action. For this to happen, research that is produced for government must be relevant and clearly communicated to the decisionmaker. The decisionmaker's commitment to the research strongly depends upon the amount of trust placed in the researcher (and the research) and his or her willingness to adopt an advocacy role within the policy process to support the researcher's position.

Social policy development involves the constant balancing of conflicting points of view. Researchers must accept this real-world circumstance and develop strategies for working within it. One such strategy is to bring in a mediator, who provides a conceptual interface between research and decisionmaking and who provides guidance in applying research knowledge to policy issues.

Acknowledgment

The description of the liquor license legislation and policy development process is based, with permission, on E. Single and B. Tocher, Legislation, Responsible Alcohol Service: An Inside View of the New Liquor Licence of Ontario, *British Journal of Addiction*, in press.

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Paving the Way for Social Change: A Research Program Designed To Stimulate Prevention Activity and Policies That Impact Licensed Drinking Settings

Tim Stockwell, Ernie Lang, and Phil Rydon

Background to Our Research Program

Research concerned with alcohol problems and licensed drinking settings was identified as a priority early on in the life of Australia's National Centre for Research into the Prevention of Drug Abuse. We had evidence that a significant proportion of instances of alcohol-related harm were preceded by drinking on licensed premises (e.g., Robb 1987; Lang et al. 1989). We were also encouraged by overseas studies that seemed to suggest that there were effective strategies available for reducing the harm associated with drinking in licensed settings (e.g., Jeffs and Saunders 1983; McKnight 1988).

We certainly enjoyed, and continue to enjoy, a supportive policy environment within which to conduct such a research program. For example, Australia's National Health Policy on Alcohol, which was approved in March 1989 by all ministers for Police and Health (Ministerial Council on Drug Strategy 1990), clearly identifies the licensed drinking environment as an important focus for prevention efforts. Despite this favorable policy climate, when we began our research endeavors in early 1989 there were few discernible prevention policies or practices in existence with the potential for having an impact on licensed premises. The only notable exception was random breath testing, which was eventually introduced into our home State of Western Australia (WA) in late 1988, bringing it in line with other Australian States. While serving a customer to the point of intoxication was an offense under liquor licensing laws in all States, it appeared that this provision was rarely, if ever, enforced by the relevant authorities. Furthermore, there were no server training programs in existence that had the explicit aim of reducing the occurrence of high levels of intoxication. Nor was there any tradition of third-party liability lawsuits being brought to bear upon licensees such as has occurred in North America (Single 1986).

Program Philosophy

The program we have developed within this climate has a strong element of action research (Reason 1988). While we have strived, as all good researchers should, to eliminate bias from our work, we have also consciously operated within a set of values derived from the relevant literature, our professional experiences, and the stated objectives of our funding body. The principal

"value," or objective, driving our work has been the desire to reduce the harm associated with drinking alcohol on licensed premises. Our principal strategy has been to conduct research and disseminate findings that will stimulate effective action toward this end.

In the classical paradigm of scientific research, it is axiomatic that any measurements employed are nonreactive—that is, the process of measurement does not alter that which is being measured. While we endeavored to minimize reactivity *at the time of measurement* in our studies, we have also consciously striven to design, conduct, and disseminate our work with a view to stimulating certain desired outcomes.

Within WA, and in Australia generally, there is a tradition of researchers and their findings being drawn into political controversies concerning alcohol policies. Typically, the alcohol industry and its representatives draw on one set of experts and one set of views while public health and citizens' lobby groups draw on others. A recent WA example concerns the continuing dispute as to whether the legal blood alcohol concentration for driving should be reduced from its current level of 0.08 to 0.05 mg/dL. In early 1990 full-page advertisements offering rival interpretations of the available research bearing on this issue appeared in the only daily statewide newspaper.

In reality, whether we like it or not, the modern day prevention researcher is a key actor in the political processes that determine the outcome of such disputes. However, awareness of this truth immediately serves up an awkward dilemma for the researcher: namely, how do you maximize the persuasiveness of your work without losing credibility, both with your peers and with the wider community, as a bona fide "scientist"? In part, the solution we have adopted is, on the one hand, to take an interactionist view of the nature of social research (Bush 1991) and, on the other, to strive—and to be seen to strive—for the highest standards of scientific rigor in collecting our politically sensitive data.

In addition to our harm-reduction orientation, the research team was also strongly influenced from the outset by the following conclusions derived from our understanding of the literature and from our personal experience with local drinking settings:

- Many licensees in Australia encourage—or fail to discourage—patrons drinking to high levels of intoxication such as BACs of 0.15 mg/dL and above.
- Drinking to such levels of intoxication is associated with a greatly increased risk of road traffic accidents and violent crime.
- A combination of law enforcement activity and server training programs offers the most practical and effective way of reducing such alcohol-related harm arising out of these settings.

Overview of Research Program

Our research program has, of necessity, been limited so far to our home State, although it is likely that future studies will involve multistate comparisons. The program has proceeded through the stages outlined below.

Development of Reliable Indicators of Harm at the Level of Individual Premises

At the outset of the program it was believed that direct measures of alcohol-related harm at the level of individual licensed premises were essential if our research was to be convincing to both policymakers and the public they serve. If changes in serving and promotional practices were to be advocated, then we believed it necessary to demonstrate that the old practices led directly to an increased risk of some measurable harm. The WA Police Department has cooperated from the outset by introducing the routine collection statewide of information concerning the last place persons who had failed a roadside breath test were drinking. This procedure includes drivers identified by random breath test units as well as those identified by police when they were called to the scene of a traffic accident. The State liquor licensing authority has also supplied annual data on the purchases of alcohol by individual licensed establishments in the previous financial year. As reported elsewhere, early analyses revealed that numbers of traffic accidents and of drinking and driving offenses involving drinkers from individual premises correlated with each other and also with annual purchases of alcohol (Stockwell et al. 1991a). On the basis of these data, a formula has been developed for calculating the "risk score" of individual premises for the involvement of their customers in drinking and driving problems:

$$\text{Risk} = \text{Harm} + \text{Estimated Annual Bar Sales}$$

where $\text{Harm} = (\text{accident cases})^* + (\text{drinking and driving only cases})^*$

*Both expressed as proportions of all such cases so as to control for the far greater volume of the latter over the former.

Identification of the Characteristics of Both High- and Low-Risk Drinking Environments

Having developed a way of using "macro-level" data to calculate these risk scores, subsequent studies have attempted to identify the crucial differences between high- and low-risk establishments. An analysis of such data simply by license type revealed that nightclubs and "hotels" (basically, Australian bars) were at higher risk than restaurants and social clubs. A more detailed study of hotels found that high-risk establishments were significantly more likely to have customers leave with BACs in excess of 0.15 mg/dL (Stockwell et al., in press). At present we are examining data concerning a variety of serving and promotional practices in relation to the risk status of premises.

BAC for drivers to 0.05 mg/dL, banning of lifestyle advertising of alcohol, conducting random breath testing more efficiently, and promoting the sale of low-alcohol drinks and the responsible service of alcohol on licensed premises. Among the strategies employed are writing to newspapers and policymakers, organizing public seminars, briefing the press on topical issues as they arise, making more formal submissions to State and Federal bodies, and publishing a quarterly newsletter that is sent free to politicians and selected journalists. Our research has been drawn on extensively in each of these types of activity where the AAC is concerned with liquor licensing issues. Members of the research team have presented the findings at public seminars organized by the AAC and attended by hospitality and alcohol industry representatives as well as Liquor and Gaming Branch officers, liquor licensing representatives, and magistrates. We have also written several articles on our work for the AAC newsletter.

Local Media

Numerous newspaper articles, radio interviews, and the occasional television show have served to publicize our research and our findings. Typically, we have been interviewed or quoted in counterpoint to the president of the WA Hotels and Hospitality Association (WAHHA), which has sometimes resulted in an exaggeration of any differences of opinion between us!

Working Party on Policing of Licensed Premises

In early 1991 we sent a brief summary of some key findings to the WA Commissioner of Police and suggested that a working party be convened to explore ways to better enforce State liquor licensing laws. This suggestion was supported and, at the time of this writing, an agreement has been negotiated between the Working Party on Policing of Licensed Premises and the Hotels and Hospitality Association for a trial of server training plus feedback on risk status to take place in a designated WA community.

Other Dissemination Strategies

Presentations describing the research findings and implications have been made to a variety of State and national audiences, notably to the WA Commissioner of Police and his senior officers, a national police conference concerned with breath testing of drinking drivers, and a State alcohol policy advisory body known as the WA Alcohol and Drug Forum. Individual presentations have been made to all members of the police working party mentioned above and to other key organizations and individuals. We have also spent valuable time observing and getting to know officers of the WA Traffic Branch and Liquor and Gaming Branch during the course of their work. A number of presentations and publications have also been prepared for more academic audiences (e.g., Stockwell et al. 1991b; Lang 1991; Rydon et al., submitted for publication).

Outcomes From the Dissemination Phase

The research team's experiences as actors in a local political arena somewhere at the interface of the hospitality industry and government regulation are best summarized separately in relation to the two principal "camps."

WA Hotels and Hospitality Association

An interesting relationship has emerged between us and the WAHHA, which is at the same time publicly adversarial and privately cooperative. Understandably, press releases and statements given out by them in relation to our research have been defensive and even hostile. They have accused us of rigging our studies in order to cast them in a bad light and of concentrating on their members at the expense of other liquor license holders more deserving of our attentions, such as the local casino, which holds a 24-hour liquor license, and the holders of "occasional" licenses for "one off" functions. Privately, however, the WAHHA director has consulted with us about the formulation of a national code of ethics for hoteliers, which he was responsible for drafting, and has invited us to advise on the curriculum for a new course for bar staff on the responsible service of alcohol—and subsequently to evaluate this course.

The main development alluded to earlier has been the agreement to cooperate on a major trial of server training in one community. The mediation of other members of the working party, especially the representatives of the liquor licensing authority and Alcohol and Drug Authority, was crucial in this regard. Another critical factor was the choice of Fremantle as the trial community. Since hosting the America's Cup in 1987, Fremantle has seen an increase in the number of liquor outlets and the community has achieved the status of a major tourism and entertainment area. Following complaints of rowdiness, vandalism, and street violence, licensees have come under increasing pressure to "clean up their act" from local residents and the city council. This experience echoes that of Mosher and colleagues (1989) who found that a climate of community concern about alcohol problems fosters the uptake of server training courses by licensed establishments.

The WA Police Department

We have continued to be surprised at the wide variations in response we have received from different police departments and from different levels even within departments.

The commissioner is an advocate of crime prevention and has been extremely supportive throughout the project. The Traffic Branch, which is responsible for implementing random breath testing, developed a statewide data collection system at our suggestion. However, a proposal to target high-risk premises identified by means of this data set was deemed too politically risky by the superintendent of this branch.

An early initiative (late 1989) from the Crime Investigation Bureau to introduce community policing of licensed premises following the Jeffs and Saunders model (1983), with our centre acting as evaluators, was quashed partly by objections from the Liquor and Gaming Branch. They argued that they were already doing all that was necessary and possible to enforce the liquor licensing laws. They believed that the use of uniformed officers for a high-profile deterrent effect would put them at risk of violence and impede them in their normal duties, that is, mainly checking for underage drinking. This branch, although represented by their superintendent at the working party described above, has also consistently argued that the laws regarding the service of alcohol to intoxicated persons are unworkable. While there are difficulties in interpreting the act, there appears to be a lack of will to intervene in this area, which has been reinforced by the courts. The reluctance of the branch to intervene may also result from the high priority they have placed on maintaining good relations with licensees at a time of severe economic recession.

Conclusions

At this time we believe that members of the research team have become actors in a dynamic political arena in which public health and commercial interests compete for the favor of both the legislators and the law enforcers. If we have learned any lesson so far it is that it is possible to retain our status as an independent research group concerned only with the minimization of alcohol-related harm while cooperating in limited ways with both the hospitality industry and the police. The maintenance of this balancing act during the conduct of the forthcoming community-based trial of server training and feedback of risk status should be challenging!

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Symposium Plenary Discussion

Louis Gliksman referred to Diane McKenzie's description of how the researcher is invited to become an "expert adviser" to the community in a straightforward way, while Tim Stockwell described a case where a researcher forced himself into a situation to give advice. "This strikes me as two really different ways of intervening," Gliksman said. "One strikes me as being a relatively easy transition and the other one a lot more difficult." Actually, Stockwell responded, his group managed to "get ourselves invited" by approaching the police in a straightforward way. McKenzie commented that in her case the invitation depended on the insight of the decisionmaker to recognize the importance of the evaluation, while in Stockwell's case this importance had to be called to the attention of the decisionmakers.

Sandra Putnam discussed situations in which data collection itself becomes an intervention, giving as an example the report forms used in the Rhode Island project. The forms ask officers making nondrinking and driving arrests whether the offender appears to have been drinking and why they think so. This raises an issue of objectivity and the question of what circumstances should prompt researchers keep their data gathering separate from other activities. Paul Duignan commented that there is no single "scientific way of doing things," and that the goal is to conduct research in a way that it will stand up.

Jan Howard speculated on the idea of a "causal model," pointing out that even if trained alcohol servers do not curtail service it does not mean their customers go out and cause car crashes. Stockwell pointed out that information derived from a local server training study can have a powerful impact on local decisionmakers simply because it is local. He added that researchers must be above reproach in the way they report their findings. He gave an example of how some data had suggested that alcohol price discounts were leading to an increase in traffic crash rates, but careful analysis of the data failed to develop any connection. This example serves as a warning to researchers not to be influenced by their own preconceived ideas.

Politics, Program Philosophy, and Evaluating Policy Change

The Intended and Unintended Consequences of Promoting "Don't Drink and Drive" Messages

Paul P. Divers and Brad M. Zipursky

Introduction

In past decades drinking and driving were often considered a regular part of a young adult's social experience. However, by the early 1980s the social climate surrounding drinking and driving changed in North America as a result of the promotion of the most recognized alcohol misuse prevention message: "Don't drink and drive" (Atkin 1988). Although the message has been successful in changing attitudes toward drinking and driving, we argue that it has not led to a reduction in alcohol consumption as is often believed. In a recent study conducted for the Alberta Alcohol and Drug Abuse Commission Divers (1990) found that young adults believed that they could consume large amounts of alcohol and still be perceived as using alcohol responsibly as long as they did not drive after drinking. Narrowly defining responsible alcohol use as not drinking and driving has prevented young adults from recognizing that the greater their alcohol consumption the more likely they are to experience physical, emotional, social, and career problems.

In this paper, we pose the following questions to prevention educators and program planners: Have promoters of a narrow don't drink and drive message provided a rationale for a significant segment of the young adult population to engage in moderate to heavy alcohol consumption? Second, do these messages meet the goal of communicating the full scope of the behavioral problems that could result from moderate to heavy alcohol consumption? By utilizing a political economy framework, we show why health and addiction practitioners need to address these questions and how this dilemma may be resolved.

The Political Economy of Alcohol Use

The answer to the above questions lies in exploring the political and economic environment in which alcohol production and consumption take place. This environment is characterized by the presence of two competing interests or agendas: the selling of beverage alcohol for revenue on the one hand and the personal and social costs associated with beverage alcohol on the other. Table 1 highlights some of the more pertinent economic benefits and social costs of alcohol use in Alberta. In comparing these costs it is evident that the production and consumption of beverage alcohol have become essential to Alberta's eco-

conomic infrastructure. This fact is evident in employment, manufacturing, and sales and tax revenues. Overall, revenue generated exceeded \$1 billion, or 1.3 percent of the gross provincial product. Conversely, the harm resulting from the abuse and misuse of alcohol severely limits benefits of this economic activity. This fact is evident from the huge social costs of personal health difficulties, problems with the law, and alcohol-related motor vehicle injuries, totaling just under \$1 billion.

It is surprising that the alcohol beverage industry has remained profitable despite a 26-percent decline in per capita alcohol sales in Alberta. However, aggregated alcohol consumption rates are misleading because consumption is unevenly distributed throughout the current drinking population (see table 2). Although there has been a general trend toward moderation in drinking, young adults' consumption patterns have remained relatively stable throughout the past decade (National Institute on Drug Abuse 1990). Consequently, as other segments of the population experience a decline in alcohol consumption, governments and the beverage alcohol industry have become increasingly dependent on the highest consuming group in the population for revenue from the sale of alcohol—namely, young male adults (Jacobson and Atkins 1983).

Table 1. The economic benefits and social costs of alcohol in Alberta

Alcohol as a revenue-generating commodity

Sales and tax revenue

- The Alberta brewing industry alone reported that it contributed \$140.3 million in various taxes to Provincial revenues (AADAC 1989).
- The Alberta government received an additional 38.7%, 49.9%, and 56.9% of the total cost of a case of beer, a bottle of wine, and a bottle of distilled spirits, respectively.
- The Alberta Liquor Control Board, owned and operated by the Alberta government, sold a total of over 200 million liters of beverage alcohol (or 70.9% of total alcohol sales in 1987), worth \$942.3 million.
- After operating expenses of \$73 million, the Alberta Liquor Control Board had a net income of \$359.8 million.

Alcohol as a hazardous commodity

Impaired driving

- In 1990, there were 1,997 alcohol-related casualty collisions in Alberta.
- The total social costs per injury are estimated at about \$460,000 for nonfatal collisions and \$688,000 for fatal collisions (Alberta Solicitor General, 1988).
- Adding costs of serious injuries and fatalities, the total legal and medical expenses were about \$51.5 million, and the total social costs are estimated at \$844.5 million.
- In 1990 the estimated total social costs of motor vehicle injuries involving alcohol were over \$896 million.

Table 2 also illustrates that the segment of the population that contributes the greatest social costs is also the group that has the highest alcohol consumption rate—young male adults. Focusing on individuals who are at risk, by far the highest rate of drinking and driving is reported by young males ages 18 to 24. Therefore, 18- to 24-year-olds generate significant social costs due to their drinking and driving behavior.

This brief summary of the political and economic environment illustrates that, on the one hand, alcohol consumption per capita has decreased throughout the 1980s while young adults remained the highest consuming group in the population. On the other hand, social costs have remained high because the percentage of young adults involved in these collisions has remained constant.

Table 2. Consumption and drinking and driving patterns

Consumption patterns

- In 1989 78% of the Canadian adult population, compared with 82% of the Alberta adult population, were current drinkers.
- The greatest proportion of current drinkers in the population were 18- to 24-year-olds (90%) (Health and Welfare Canada 1990).
- Alberta men consume more alcohol per sitting than women: 41% vs. 26.7% consume 5+ drinks (many), 33.1% vs. 32.6% consume 3–4 drinks (several), and 25.4% vs. 40.7% consume 1–2 drinks (few) (Divers 1990).
- The lowest consuming group is female school attenders: 25% consume many, 29.5% consume several, and 45.5% consume few.
- The second highest consuming groups are male attenders and female non-attenders: 28.6% and 29.7% consume many, 35.7% and 34.4% consume several, and 35.7% and 34.4% consume few, respectively.
- Male nonattenders are the highest consumers of alcohol: 51.3% consume many, 30.8% consume several, and 17.9% consume few.

Drinking and driving patterns

- In Canada almost 25% of all collisions involve alcohol.
- In Alberta 9.4% of drivers involved in injury crashes consumed alcohol prior to the collision, compared with 22.1% of drivers involved in fatal collisions.
- In Canada 32% of 18- to 24-year-olds reported driving after drinking; 41% of this group were men (Health and Welfare Canada 1988).
- In Alberta 50% of young adults reported driving after drinking; 38% of this group were men (AADAC 1989, 1990).
- Of the 1997 Alberta alcohol-related casualty collisions, 649 (32.5%) involved young adults; men were six times more likely than women to have a collision.
- Alcohol misuse among young adults contributed \$300 million (34%) of the total \$896 million resulting from alcohol-related casualty collisions in Alberta (Alberta Traffic Collision Statistics 1990).

The Role of Don't Drink and Drive Messages in Managing the Environment

Conventional wisdom suggests that the more resources dedicated to the reduction of alcohol misuse the more it would erode the economic benefits from the sale of alcohol. Why, then, would beverage alcohol producers and governments who are dependent on alcohol revenue to varying degrees promote moderation? This point was raised by Jacobson and Atkins:

Despite the alcoholic beverage industry's sanctimonious pleas for people to drink in moderation, the industry would suffer a severe shrinkage if everyone took its advice....[It has been] estimated that if all 105 million [U.S.] drinkers of legal age consumed the official maximum "moderate" amount of alcohol...the industry would suffer a whopping 40 percent decrease in the sale of beer, wine and distilled spirits, based on 1981 sales figures (Jacobson and Atkins 1983: p. 6).

More important, given that 50 percent to 70 percent of alcohol is consumed by young adults, the targets of responsible drinking messages, the industry would be severely crippled if this age group actually took them seriously. Yet, the beverage alcohol industry has remained profitable and this bleak forecast has failed to materialize. It is not because people consider the message irrelevant. In fact, Canadians ranked drinking and driving as the number one social problem (Health and Welfare Canada 1988). On the contrary, economic devastation was avoided by proactively promoting a don't drink and drive message.

The element that makes the don't drink and drive message an effective strategy for managing the environment is its focus on eliminating the risks associated with the combination of drinking *and* driving, *not* just on the risks associated with drinking. This message manages the political and economic environment by only discouraging alcohol use prior to driving, implying that driving while impaired is the only alcohol problem facing young adults. It fails to address the other problems associated with alcohol misuse such as addiction, work or school difficulties, relationship problems, accidents or injury besides casualty collisions, and legal problems. It is through the promotion of this message that governments and beverage alcohol manufacturers are able to achieve a balance between addressing the social costs associated with drinking and driving and maintaining a steady flow of revenue through alcohol consumption.

The creation of the message is based on the assumption that *most* people do not experience problems from drinking, but rather from the choices they make afterward such as deciding to drink and drive. Consequently, a primary objective of the message is to place a context around responsible drinking which provides alternatives to drinking and driving without directly affecting drinking behavior.

For example, Labatt's latest print and billboard advertising uses two different images seen in quick succession through adjacent placement in magazines and newspapers. The first image is Labatt's beer in a clear beer stein overflowing with their product below the caption "First Call." The second image is the top light on a taxicab below the caption "Last Call, Thanks for Not Drinking and Driving." According to Labatt's, the intent of the advertisement is to make the public think twice about drinking and driving and "make the right call" (Labatt's 1990: p. 4). However, the ad also implies that the right call is first drinking Labatt's beer from the moment you start drinking until last call, and then worry about not drinking and driving. Although it is not said explicitly, the implicit message is that when you go out, plan to drink until intoxicated (the first call) and then call a taxicab (the last call). If Labatt's was genuinely promoting responsible drinking, then their caption would address planning before drinking rather than drinking before planning.

Through the subtle alcohol promotion contained in the don't drink and drive message, governments and beverage alcohol producers are able to maintain a balance between addressing the social costs associated with drinking and driving without significantly reducing revenue generated through alcohol consumption. In the next section we argue that the effects of promoting this message may not result in significant behavior changes but, rather, may be more subtle in terms of creating a new culture.

The Emergence of a New Culture: A Programming Dilemma

Today's young adults are members of the first cohort to have been raised in a social environment where these messages have been available in the mass media from childhood. The result may be a new culture that is characterized by positive attitudes concerning alcohol consumption juxtaposed with contradictory behavioral translations of those attitudes. Consequently, young adults have internalized the don't drink and drive message, but have failed to recognize that this is only one behavioral component of responsible alcohol consumption.

This culture was partly created by the alcohol manufacturers' advertising that consumption of their product is a means to achieve the ideal lifestyle. At the same time, health agencies, governments, special interest groups, and the breweries have inundated young adults with a variety of responsible alcohol use messages with the principal focus on the consequences of drinking and driving. Consequently, young adults are confronted with mixed messages that they reconcile through the creation of myth.

Myths, in the terminology of the semiotician Roland Barthes, are unconscious assumptions of culture that are learned to such an extent and so profoundly buried that we think they are part of nature (Barthes 1973). A

myth is not a cultural belief that is "false." It is a belief so widely accepted and ingrained within a given culture that the question of its veracity is rarely raised. The myth is that young adults perceive themselves as being responsible drinkers regardless of the amount they consume, as long as they do not drive after drinking. This belief is so taken for granted that young adults have unconsciously transformed the intent of this message in a manner that makes heavy alcohol consumption more culturally acceptable for them personally, but maintains the social unacceptability of drinking *and* driving for themselves and others. This fact became evident in the Divers (1990) study during focus group testing of young adults when they were asked "how do you define responsible drinking?"¹ Most of the participants believed that responsible drinking meant not drinking at all. One of the followup questions to the participants included "if responsible drinking was not drinking at all—and you do drink—does that mean you are not responsible drinkers?" The prod tended to encourage variations of the previous definition. Typical responses included the following:

"Knowing how much you can drink before it gets out of hand or before you stop worrying about everything else."

"Being able to set a limit—knowing how much you can drink and sticking to it." (*Focus Test Interviews, September 1990*)

Few young adults were able to explicitly define responsible alcohol consumption the way that addictions and health practitioners would define it. This fact became evident when young adults were asked what type of media campaign would influence them to consume alcohol responsibly. Invariably, most reported "scare tactics" related to drinking and driving:

"Blood and gore works...show a smashed up car with someone dead inside."

"The message that you need to focus on is 'don't drink and drive'—show some accidents due to drinking."

"Show some people having a really good time. Then show them getting into a car and driving home...but then they don't make it." (*Focus Test Interviews, September, 1990*)

The myth surrounding responsible alcohol consumption also manifests itself in the fact that young adults are able to articulate the personal and social problems resulting from the heavy alcohol consumption of others. Young adults generally tended to attribute negative consequences of alcohol misuse to intoxicated strangers:

"They disgust me...I think they are pathetic and I have no respect for them."

"Shows immaturity to me." (*Focus Test Interviews, September 1990*)

Interestingly, the stories that young adults told concerning the state of intoxicated strangers tended to resemble the stories they revealed about themselves or an intoxicated friend. Yet, these situations were remembered with fondness:

"When we talk about the past and the fun times it's always about times when we were drinking lots."

"Do you remember when we were drunk at _____ we would take turns blowing into the breathalyser?" (*Focus Test Interviews, September 1990*)

However, these young people are unable to recognize that the greater *their* alcohol consumption, the more likely *they* are to experience problems at work or school, trouble with police, difficulties with friends, relationship problems, family problems, and drinking and driving problems (Divers 1990). Table 3 reveals that the more alcohol young adults consume, the more likely they are to experience difficulties associated with heavy drinking. It is interesting to note that "driven while impaired" accounts for the least amount of difficulties encountered after drinking compared with other situations. Difficulties encountered because of drinking tend to surface more often in school and work and in relationships with others (i.e., police, friends, dates, and parents and family).

Program Issues, Strategies, and Directions

The above discussion puts us in a position to address the questions posed at the outset. Although the don't drink and drive message appeared to be straightforward and well thought out by its creators, it has not resulted in the

Table 3. Tests of association between difficulties encountered due to drinking by the amount consumed per sitting, Alberta urban young adults, 1988

1. Trouble at school/work	$\chi^2(4,342) = 36.489, p < .01, \text{gamma} = .794$
2. Difficulties with friends	$\chi^2(4,342) = 53.097, p < .01, \text{gamma} = .639$
3. Driven while impaired	$\chi^2(4,342) = 30.853, p < .01, \text{gamma} = .451$
4. Criticized by a date	$\chi^2(4,342) = 33.437, p < .01, \text{gamma} = .590$
5. Trouble with police	$\chi^2(4,342) = 32.625, p < .01, \text{gamma} = .705$
6. Trouble with parents/family	$\chi^2(4,342) = 30.501, p < .01, \text{gamma} = .555$

NOTE: Only those young adults who reported that they do consume alcohol were included. Amount consumed was measured on an ordinal scale: few (1-2 drinks); several (3-4 drinks); many (5 or more drinks). Difficulties due to drinking were measured on an ordinal scale: never, 1-3 times, 4 or more times. (Source: Divers 1990).

intended behavioral outcomes for which it was designed by prevention educators and planners. This situation is less a result of poor planning than of the changing nature of the political economic environment from which the message emerged and how young adults have incorporated it into their alcohol use decisions. Discovering that the notion of responsible decisionmaking regarding alcohol use has been reduced to a don't drink and drive message leaves alcohol abuse prevention planners with several programming issues. In this section we outline the issues and provide a framework for effective intervention.

Program Issues

Addressing alcohol consumption behavior and personal risks associated with alcohol misuse

The Political Economy of Alcohol Use made it clear that consumption and risk of injury should be addressed simultaneously. Risks associated with drinking and driving can only be reduced if we affect the consumption patterns of young adults.

Eliminating the term "responsible drinking" from the message

In the Role of "Don't Drink and Drive" Messages in Managing the Environment section we illustrated that the responsible drinking message provided by the breweries created a situation where young adults equated responsible drinking with not drinking and driving, which placed the focus on drinking *and* driving, *not* just on drinking. Consequently, young adults interpret the term "responsible" to mean that they can consume heavy amounts of alcohol as long as they don't drink and drive.

Deconstructing the cultural myth versus changing attitudes

In The Emergence of a New Culture section we suggested that a new culture has emerged that is characterized by an inconsistency between positive and healthy attitudes toward alcohol use and a belief that heavy alcohol consumption is socially acceptable in early adulthood. This inconsistency is resolved through the creation of the cultural myth.

The key to addressing each of these issues is finding ways to reduce the risk behavior associated with alcohol misuse. Moreover, we cannot continue to expect that young adults will recognize on their own that the don't drink and drive message may have influenced their conception of responsible alcohol use. In our view, the key to influencing alcohol use behaviors among young adults lies in the implementation of a social marketing approach.

Strategies and Program Directions

Social marketing is defined as "the design, implementation, and control of programs seeking to increase the acceptability of a social idea or practice in a target group" (Kotler 1982: p. 15). Social marketing provides a systematic way

of thinking about a particular behavior change over the long term. Rather than simply raising awareness of an issue through straight information exchange as in an education approach, social marketing focuses on the people and groups we want to influence. Table 4 outlines the stages involved in developing a social marketing or communication program. Our intent is not to develop a social marketing program to address alcohol use among young adults, but to provide a framework through which the above issues can be addressed.

Social marketing's value to addiction and health programmers is its emphasis on systematic research. Although the research techniques used in social marketing are no different from those used in social science research, there is a difference in how the research findings are used. Research conducted within the social marketing framework described above assists the program planner in making decisions based on facts rather than on speculation, which ultimately increases the likelihood of achieving the desired behavior changes. One reason that many campaigns to combat substance abuse have achieved limited effectiveness is their lack of adequate evaluation research. As Atkin stated, "typically, goals are formulated and messages produced in an unsystematic fashion based on hunches of program planners and creative inspirations of copywriters and artists, patterned after normative standards of the genre" (1988: p. 23). A commitment to sound, ongoing research both in the development and evaluation phases of the social marketing program is critical.

Table 4. The social marketing process

Stage One Situational Analysis	Stage Two Strategizing	Stage Three Implementation
1. Problem definition 2. Consumer analysis 3. Channel analysis	4. Goal setting 5. Target market segmentation 6. Determining the marketing mix	7. Evaluation

Having provided the social marketing framework, we are now in a position to offer the key program direction resulting from our study to help guide health and addiction organizations through the social marketing process. In the next section we identify five possible program directions.

Program Directions

- Prevention campaigns addressing alcohol consumption should concentrate on drinking behaviors. As discussed in this paper, reported attitudes do not necessarily translate into behavior modification. Consequently, we need to emphasize that the actions of young people after drinking are what gets them into difficulties, not their attitudes. Driving after drinking is only symptomatic of poor action management. Program planners could capitalize on a lifestyle approach by focusing on the effects of certain alcohol use behaviors on present

and future lifestyle decisions. These campaigns should emphasize personal success, where such success depends on the choices young adults make in their lives.

- Prevention messages for young adults should target those at highest risk: persons not attending a postsecondary school. Emphasis should be placed on work setting programs designed to reach young adults not attending postsecondary institutions since they represent the largest proportion of excessive drinkers in our study, and are thus the group at highest risk for experiencing alcohol-related problems. The secondary target should be 18- to 24-year-old persons who attend postsecondary schools.

- Prevention messages for young adults need to be multifaceted. To offset the drinking and driving campaigns provided by various breweries, program planners should implement a multifaceted message and design resource materials emphasizing the importance of time management, grades, and lifestyle, all of which are affected by excessive alcohol consumption.

- Three of the more promising campaign approaches that came out of focus group tests in the Divers (1990) study follow:

- Focus test participants believed that everyone possesses a "little voice" that lets them know when they are losing control of their alcohol intake. Participants believed that if young adults were reminded of this "little voice," they would begin to pay attention to it before they crossed the boundary between responsible drinking and irresponsible drinking.

- Images of intoxicated friends versus images of intoxicated strangers may also have some merit. Focus test participants suggested that intoxicated friends were a source of amusement while intoxicated strangers were perceived as ignorant and disgusting. A presentation focused on the similarities between the two situations might help young adults begin to recognize that intoxicated individuals are those who have lost control of their drinking.

- Young adults often believed that heavy consumption was a stage in their lives that they would eventually leave behind. It seems reasonable, then, to establish a campaign that shows that excessive consumption as a young person can, and often does, lead to heavy consumption as an older person.

- There is ample opportunity for program planners to address the awareness needs of these young adults through mass media campaigns. Given present-day budgetary constraints, program planners should attempt to solicit funding from corporate sponsors because lost days and low productivity are often associated with alcohol use, especially among young adults. It seems reasonable that such prevention measures would be, in the long run, a financial saving to most companies. By developing such partnerships we will regain

control of the original responsible decisionmaking approach. This step is necessary if program planners are to offset the unintended behavioral consequences of the don't drink and drive message and to be in a position to replace that message with one specifically designed to achieve the intended changes in the drinking behavior of young adults.

Notes

1. Focus group participants were selected through a technique known as the "best friends" approach. Contacts were made with several young adults who were then asked to bring friends with them. Our rationale for choosing this approach was that contact individuals would, in all likelihood, bring friends with whom they were most likely to drink. Our sample for the focus tests consisted of 24 postsecondary school attenders and 24 nonattenders.

2. Because of space limitations, we are unable to provide a comprehensive discussion of social marketing strategies here. Instead, we refer the reader to the writings of Kotler (1982), Mintz (1989), and Tanguay (1989).

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Tobacco Regulation in Canada: Evaluating the Roles of Advocacy and Community Involvement in Affecting Public Policy

Roberta G. Ferrence and Ludovic D'Souza

Introduction

During the past 10 years Canada has become a world leader in the control of the sale, promotion, and public use of tobacco. This presentation outlines developments in the regulation of tobacco in Canada, describes strategies used by advocacy groups and health organizations to make these changes, and evaluates them in terms of their influence on policy changes.¹ A case study approach is used to examine efforts at the Federal, Provincial, and municipal levels and the ways in which they interact. These results are used to make recommendations for promoting both tobacco and alcohol control measures in the United States and elsewhere. Methodological issues in evaluating comprehensive substance control strategies are also discussed.

Canada has implemented significant legislation at all three levels of government. Federally, the Tobacco Products Control Act (Health and Welfare Canada 1989) prohibits brand-name advertising of tobacco products, requires the reporting of the monetary value of tobacco company sponsorship, and requires the placement of highly visible warnings on cigarette packages and package inserts. The Non-Smokers' Health Act requires smoke-free workplaces for Federal employees and on air carriers and other public transit. Young people under age 16 may not legally purchase or use tobacco. Provincial legislation in Ontario allows only small designated smoking areas in workplaces, and many municipalities have gone beyond this step to prohibit smoking in the workplace and in other public places. A number of Provinces, including Ontario, forbid sales to minors under age 18. Some municipalities require licensing of tobacco vendors.

The government of Ontario is developing a comprehensive tobacco control strategy that focuses on sales to minors. Options being considered are the licensing of retail outlets with fines and license revocation as penalties for illegal sales, a reduction in the number and type of retail outlets, the formation of a tobacco control board for the Province, a ban on tobacco vending machines, raising the age of purchase beyond the current age of 18, generic (plain) packaging, and a ban on imitation tobacco products. Current proposals in Toronto include options for complete bans in all workplaces and public places, a ban on tobacco vending machines, and an end to tobacco sponsorship of sports and cultural events.

Since 1981 substantial tax increases have been implemented regularly at

both Federal and Provincial levels. Taxes now constitute more than two-thirds of the price of cigarettes, which cost approximately \$5.00 Cdn for a pack of 20 cigarettes (about \$4.60 U.S.). (While most European countries have similarly high taxes on tobacco, some as high as 80 percent, U.S. tobacco taxes constitute only 27 percent of retail price.)

These measures have produced appreciable results. Most significantly, during the 1980s per capita consumption declined 28 percent among adults and 61 percent among adolescents ages 15 to 19. Per capita sales of all tobacco products have declined 43.4 percent since 1982 and 14.8 percent in the past year² (M. Goodyear, personal communication). Smoking in public places has been reduced substantially, and advertising and promotion have been largely eliminated.

A few individuals in advocacy and health organizations were instrumental in developing coalitions and lobbying at the Federal and Provincial levels. While major changes have occurred federally under both Conservative and Liberal governments, the most dramatic changes will probably come under the current New Democratic Party government in Ontario. Here, the strategy has involved both advocacy and health organizations and ministry staff. Municipally, public health departments have played a key role along with elected officials and advocacy groups.

Case Studies in Tobacco Advocacy

Two major campaigns have been carried out in Canada (one is still in progress) to promote antitobacco health strategies.

The National Campaign to Pass Bill C-51 (the Tobacco Products Control Act 1989)

The National Campaign to Pass the Tobacco Products Control Act involved about 25 organizations representing health agencies, teachers, physicians, and churches. However, the driving force for the campaign came from two organizations, the Non-Smokers' Rights Association (NSRA), a small, highly active, privately funded advocacy group, and the Canadian Cancer Society (CCS), the first voluntary organization to hire a full-time health lobbyist. The group did not start from scratch; some members had been active since the 1970s, employing a variety of high-profile techniques to direct public attention to tobacco issues.

The focus of the campaign was to present tobacco as a lethal drug that, when taken exactly as intended, killed far more people than major world wars and continues to be a serious drain on the economy. The tobacco industry was described as a "rogue industry" that gives legitimate industry a bad name. The business community was upbraided for not treating the problem as seriously as other less lethal drug problems.

Implementing the strategy

Several strategies were instrumental in the passage of this bill. At the outset, the NSRA had successfully lobbied the health minister, who became a strong ally in the process. The media were used to undermine industry opposition to the proposed legislation. A full-page spread in a major newspaper with photos of the prime minister and a prominent lobbyist hired by the tobacco industry, along with information about their previous close business contacts, was widely credited with saving the legislation. Concurrently, a "war room" set up close to Parliament Hill was the scene of intense lobbying of members of parliament and physicians for more than a year.

Outcome of the campaign

The ban on media advertising came into effect at the beginning of 1989. (The act was later challenged in court by the tobacco industry and the resulting decision appealed by the government; however, the advertising ban stays in effect until the appeal process ends.) Public support for the ban is substantial, with about two-thirds of Ontarians expressing support in 1991 (Ferrence 1991). The challenge to the legislation and the appeal have held up use of new warning labels. However, it is unlikely that the ban will be reversed when the appeal ends.

The Ontario Campaign for Action on Tobacco

Plans for a Provincial tobacco control strategy have been discussed for several years, but came under serious consideration when the New Democratic Party came to power in Ontario in November 1990. In conjunction with the release of the provincial budget in April 1991, the ministry announced that it would present a comprehensive plan to deal with tobacco. A November 1991 report from the Provincial medical officer of health outlined the health problems associated with tobacco and the ministry's commitment to deal with them. The process was delayed, in part because a new health minister took office, and the first announcement of the strategy was not made until January 20, 1992. The ministry adopted measures recommended by the premier's Health Council, which included seeking a 50-percent reduction in tobacco use, providing financial support for community-based tobacco reduction efforts, and making a commitment to law reform. Reforms being considered include measures already implemented in other jurisdictions, for example, banning vending machines and suspending licenses of retailers convicted of selling to minors. Generic or plain packaging,³ a new measure, was popularized and promoted in Canada by the NSRA, who imported the concept from New Zealand.

Throughout the development process, ministry staff were in regular contact with health and advocacy groups in the community. In response to concerns that the government might water down or delay their strategy, a formal

coalition of advocacy and health groups was formed in October 1991. This coalition was initiated by a smaller group comprising the NSRA, the Council for a Tobacco-Free Ontario (CTFO), the CCS, and Physicians for a Smoke-Free Canada (PSFC), who had been meeting since July 1989 on the need for a comprehensive Provincial strategy for tobacco control.

The eight prescriptions

The organizers sought out the support of the health community specifically to endorse the group's eight-point plan to address the tobacco epidemic. The decision was made to frame the campaign in terms of public health and health promotion for children. The eight points of the plan were termed "prescriptions." A photo of eight smiling prepubescent children, culturally and gender representative of Ontario's population, was placed above the campaign title "Give Kids a Chance." Tobacco use was referred to as the "No. 1 drug addiction," and its health consequences were called "The Tobacco Epidemic."

This terminology was deliberate. Organizers wanted to keep the public and government thinking of tobacco use as a public health issue. The tobacco industry has attempted to move the debate to the commercial and legal arena, with its publicized concern for individual freedom to purchase and use tobacco, the right of manufacturers to promote a legal product, and the right of smokers to smoke in public places. By focusing on kids just a year or two younger than the typical age of first use (11 or 12) the campaign was able to clearly identify underage sales as the issue. (These sales are promoted by the tobacco industry,⁴ but officially are disavowed.) The pamphlet addresses a number of concerns raised by the public and the press, including smuggling, high taxes, and the prospective loss of jobs in the tobacco industry.

The pamphlet encourages the public to lobby their members of Parliament and the health minister to support the eight prescriptions. Although strengthening public education campaigns is one of the prescriptions, the pamphlet supports a California-style campaign in which the industry, rather than individuals, is clearly targeted, and the messages are hard hitting.

Implementing the strategy

At this point, 15 organizations have officially endorsed the campaign. In addition to antitobacco advocacy groups, endorsers include the major voluntary health organizations (heart, lung, and cancer), as well as medical, public health, and educational groups. While support in principle was forthcoming from many organizations, there was disagreement about the specific plan for action. The key point of contention had to do with the decisionmaking process. It was argued that the campaign had to respond quickly to external changes and could not always wait for head office approval from member organizations. Although ARF is a member of the CTFO, it did not officially endorse the campaign. However, it launched its own activities, which included a "best

advice" paper on recommended policy strategies and a background paper providing science-based policy options.

Evaluating the campaign

The campaign is still in progress, but some information is available to assess its effect. Campaign materials were distributed to about 500 organizations, including all local tobacco and health councils, health and human services groups, medical officers of health, Provincial members of Parliament and Provincial tobacco and health councils, with instructions to copy for campaign organizers any letters they send to the Ontario legislators. To date, about 50 percent have responded. Many of these organizations have distributed materials internally to volunteers, donors, and staff. The CSC, Ontario Division, for example, has completed 15,000 mailings, which could potentially result in an equal number of submissions to members of the legislature.

Methodological Issues in Evaluating Comprehensive Substance Control Strategies

Strategies involving legislation provide clearer outcome measures and are in some ways easier to evaluate than educational measures involving changes in attitudes and knowledge. Regulations get passed or they do not. Assessing the development process for any campaign requires a detailed plan and method for measuring involvement or compliance.

Field experiments that compare communities with and without a developer who has been given instructions to get residents organized around a certain issue may not show a substantial effect because of the lack of a major, highly focused coordinated effort that operates at several levels. However, some local efforts have been highly effective, including the Edmonton, Alberta, campaign to eliminate tobacco sales to minors. In this case, the involvement of a strong advocacy group, Action on Smoking and Health (ASH), was a key factor in the campaign's success. The campaign, Compliance for Kids, combined a comprehensive merchant education program with lobbying for license suspensions for sales to minors.

Key Elements in Efforts to Promote Tobacco Control Measures

The Canadian experience provides some important guidelines for promoting tobacco control measures:

- Campaigns should focus clearly on public health. Rather than tackling the industry on its own turf, which usually involves legal, economic, and free speech issues, organizers should stick to their own area of expertise. Attempts to discredit industry tactics by using data on mortality, morbidity, and the

targeting of minors are more likely to be effective than getting involved in issues of commercial freedom.

- Advocacy groups must be creative and focused in their approaches to promoting control measures because, compared with the tobacco industry, they are invariably underfunded. Tightly coordinated campaigns that are well publicized and present the issues in novel ways are typical of the Canadian campaigns. The use of a full-page ad during the campaign to pass the Tobacco Products Control Act was controversial and not unanimously supported by campaign members; however, it proved to be a turning point in the campaign.

- Effective campaigns have relied heavily on accessible grassroots networks. Community organization and support provide a foundation that appears to be critical in mounting a broadly based campaign and maintaining support over long periods.

- A history of activity at the municipal level is an important prerequisite for generating support—provincially or federally. Municipalities provide important models for higher levels of government, which tend to follow the lower levels when implementing control policies. While many measures are technically in the Federal or Provincial/State domains, municipalities can usually enact their own legislation. If a regulation flies locally, higher levels of government feel more comfortable in promoting and adopting it.

- Adequate funds must be obtained to carry out an advocacy campaign. The California campaign for Proposition 99 (earmarked tobacco tax) cost \$10 million. Canadian groups estimate they will need \$2 million to lobby effectively for a tobacco control strategy in Ontario.

- Tradeoffs are involved in both small and large coalitions. Small groups are able to respond more quickly to external events and to hit harder because there are fewer interests at stake and they are less likely to disagree about strategy. Larger groups are more representative of the health community, may pull more political weight, and may provide greater access to financial and human resources. However, the larger groups may have members who balk at the use of controversial tactics and messages because of concerns about financial support from donors and because they are unused to aggressive tactics.

- A consistent level of advocacy activity is critical. Although we have presented these campaigns as separate efforts, they should be viewed in the larger context of tobacco control advocacy in Canada. There is continuity in the leadership of campaigns; NSRA staff is involved in all major efforts and other organizations in many of them. The advocacy constituency is continuously involved in antitobacco activity; there are no down periods between campaigns; and highly visible campaigns result from months and often years of planning and preparatory work.

The most successful tobacco control efforts have been those that sought legislative and fiscal reforms that were clearly aimed at changing behavior. The ultimate criteria for success are decreasing per capita consumption of tobacco, decreasing the prevalence of smoking and heavy smoking, and reducing rates of initiation among young people. Most Canadian campaigns have sought regulatory change as a means of reducing tobacco use; however, many U.S. campaigns have been directed toward public education. Even the California campaign (Proposition 99), which successfully introduced an earmarked tobacco tax, produced much media advocacy, but little in the way of other regulatory change.

Canada has a much smaller population, perhaps making it easier to organize, and Canadians have traditionally been more tolerant of government regulation. The success of the California campaign, however, suggests that efforts to promote tobacco regulation in the United States could result in significant change.

What Can Alcohol Control Advocates Learn From the Tobacco Experience?

Lessons learned in the tobacco area can be applied to efforts to control alcohol. The task is more difficult because the majority of drinkers do not experience or cause serious health or social problems. However, there is evidence in Canada that the level of public support for alcohol control measures is close to that for tobacco control measures (Ferrence 1991). There is a solid database on death, disability, and social problems resulting from alcohol use, which could be employed in the way it has been for tobacco.

Organizations that engage in advocacy work, such as the Marin Institute and the Prevention Research Group, have carried out significant efforts in the alcohol area. Effective change, however, requires a major shift in public opinion. Canadian support for regulatory measures is generally higher for those measures already in force; that is, changes in public opinion appear to follow as well as precede regulatory change. One of the current challenges in the United States and Canada is to counteract the proponents of moderate drinking, some of whom recommend changes that would lead to increased overall consumption and resulting problems. Ultimately, the reduction of tobacco and alcohol-related problems will depend on a combination of regulatory changes and public education.

Notes

1. This presentation is based in part on materials developed by Canadian tobacco control advocates. I am indebted to Garfield Mahood, David Swenor, Rhona Lahey, and Marilyn Pope for inspiration and advice.

2. These figures are slightly inflated because of the smuggling of Canadian cigarettes exported to the United States back into Canada.

3. This measure serves several purposes: there is some evidence that children are less attracted to plain packages (Beede and Lawson 1990); packages devoid of logos and corporate symbols no longer promote the product whenever they are seen; plain packages allow for increased size and visibility of health warnings; and substantial differences in the appearance of domestic packages and those for export reduce the likelihood that the latter will be smuggled back into the country.

4. Documentation obtained during an appeal of the Tobacco Products Control Act provided evidence for the targeting of minors by the tobacco manufacturers.

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Symposium Plenary Discussion

Jan Howard asked some questions prompted by the Canadian study on drinking and driving messages. Could the decline in drinking and driving be attributed to higher taxes or to reduced consumption of alcohol? Is there any evidence that designated driver programs are leading nondrivers to drink more than they might have otherwise? Paul Divers said that aggregate impaired driving rates are misleading because they mask what is really occurring among young adults, who are overrepresented in casualty collisions. Brad Zipursky pointed out that there had been declines in overall consumption of alcohol, but not in the 18- to 24-year-old age group, where both consumption and rates of impaired driving have remained constant. He added that in Alberta there are designated driver programs only at colleges and universities. The colleges receive funds from breweries that sponsor campus events and support designated driver programs.

Robin Room said he believes the issue has to do with goals: "Do we follow the lead of the tobacco people and try to get people to drink as little as possible, or perhaps more than that, to abstain? Or do we stick with the harm reduction model and simply move to a wider definition of harm, when we know we'll probably have a hard time talking teenagers out of drinking because they might get cirrhosis in their sixties?" He said that after the campaigning against

drinking and driving the next thing might be a campaign on the theme: "don't be a jerk, don't upset your family and friends, don't do stupid things while drinking." This leads to the question of whether you are going to try to get people to drink less or to affect their expectancies while they are drinking.

Zipursky discussed lessons learned from a "healthy lifestyle" movement in Alberta, which linked healthy living habits with a goal of success and achievement, making the point that spending time in a bar reduces time available for education and skills development—the ingredients of success. This suggests that prevention messages aimed at changing behavior should be based on the values and aspirations of the people you want to affect.

Michael Hilton referred to Roberta Ferrence's report of wide public support for prevention and said data of this kind might be considered a tool within a community prevention effort. He pointed out that the enormous support for a workplace ban on smoking was an unusual finding, considering that workers generally resist such intrusions.

Commenting on Room's remarks, Alex Wagenaar said he believed most preventionists supported the idea of harm minimization. He recalled Lawrence Ross's suggestion that free taxi service from 10 p.m. to 3 a.m. might be less expensive than some alternatives for reducing drinking and driving risks. "We want to make sure that if we implement such a policy or program we're not creating deleterious side effects, trading off one social problem for another," Wagenaar said. The field does not know enough about designated driver programs to say whether they encourage drinkers to become more intoxicated than they otherwise would. Turning to Ferrence's discussion of the interaction between the alcohol and tobacco fields, he offered an example from Minnesota where a community adopted an ordinance permitting only over-the-counter sale of tobacco. At a hearing on the ordinance Wagenaar mentioned that the same principles could be applied to regulating the sale of alcohol. City officials then told him they wanted to develop a similar ordinance for alcohol. Ferrence commented that her survey showed support for limitations on alcohol advertising was only slightly lower than support for limitations on advertising tobacco, and support on both issues came mostly from the same people. Paul Duignan suggested there are implications in linking alcohol and tobacco prevention policies that could be used by one industry or the other to their own advantage—in the debate on advertising restrictions, for instance—and that this should be considered when planning strategies.

Further commentary on the issue raised by Wagenaar came from Fried Wittman, who said that when the alcoholic beverage industry offers money to low-income organizations it leaves them with a Hobson's choice of using it in ways the industry wants. The presentation by Divers and Zipursky, he said, points out how acceptance of industry money puts a community on a "slippery slope." Professionals from the prevention field can help communities by leading them through an analysis of what it means to take money under such circumstances.

The Intersection of Community Prevention and National Politics

Community Policy: How a New Movement for Policy Changes To Prevent Excessive Drinking Was Built in Kibbutzim in Israel

Shoshana Weiss

Introduction

"Kibbutz" means group in Hebrew. The Kibbutz is a purely homegrown product of Israel. It is a voluntary democratic community where people live and work noncompetitively and where all land, property, means of production, and products are owned, used, and marketed collectively. Everything earned is shared by the whole community. The aim of the Kibbutzim (plural of Kibbutz) is to live as an economically and socially independent society founded on principles of communal ownership of property, social justice, and equality of opportunities, responsibility, and status. The first Kibbutz was founded in 1909. The times, place, and circumstances were right for the birth of this type of community. The people then found it the most practical way to live in the conditions with which they had to cope. Today some 260 Kibbutzim are spread throughout Israel. With a total population of around 120,000, they represent about 3 percent of Israel's population. Each Kibbutz is an autonomous entity and is responsible for its own economic development and cultural and educational structures. The Kibbutzim are organized into several movements such as Hakibutz Haartzi and the United Kibbutzim Movement-Hatakam.

Today, the Kibbutzim face a new reality. On the one hand, there is a fear that in adapting to changing circumstances they are moving dangerously far from their original principles, and, on the other hand, there is a belief that their ability to compromise is the secret to their survival. During recent years the Kibbutzim have faced drastic problems that have influenced their activities and policies (and probably caused their founders to turn in their graves).

Economic Changes

Because of the limited availability of land and water and limited profitability, many Kibbutzim have found it necessary not to rely on agriculture as their basic enterprise, but to branch out into industry. Lack of knowledge and intrinsic capital, wrong investments, and inflation have resulted in enormous debts, and the Kibbutzim no longer get subsidies from the (right-oriented)

government. Thus they have evolved into economic entities that have to generate profits and be managed as profitable organizations on a business basis.

Social Changes

When younger members grow to maturity, they may leave to join other Kibbutzim, form new ones, or leave that type of living altogether. In recent years about 50 percent of youngsters have chosen to leave the Kibbutzim, despite the fact that they have been offered 1 year of vacation and opportunities to study any subject in the universities (and not in specific domains needed in the Kibbutzim).

In some Kibbutzim children still live and grow up together in specially designed children's communal houses, cared for by adult members. However, this practice has changed in recent years, and more and more Kibbutzim have switched to "living at home"—a growing and controversial trend.

When no suitable qualified members, or too few, are available for a particular job, outside workers are hired. Hiring labor is a source of debate, for many members see it as incompatible with the underlying ideology of the Kibbutz.

Value Changes

Because of modernization, a rise in living standards in Israel, the influence of the general materialism in Israeli society, and the influence of the outside world (which has been absorbed through television, films, press, volunteers from foreign countries, and tourists), a change in values and norms has developed. For example, white-collar jobs are more valued than farming and blue-collar jobs. Members are valued according to the amounts of money they deposit into the common treasury. The family and the "family room" have become the central important bodies at the expense of the communal dining room and other common gathering places. Important decisions are not subjected in many cases to the approval of a general meeting of members but to the approval of a few elected leaders. There has been a shift from modest needs to big houses, private bank accounts, and private education and housing of family members living outside the Kibbutzim. The "equality rule" has gradually died. Under the influence of the surrounding urban population, there also has been a shift in the Kibbutzim toward involvement in foreign leisure activities such as drinking in pubs.

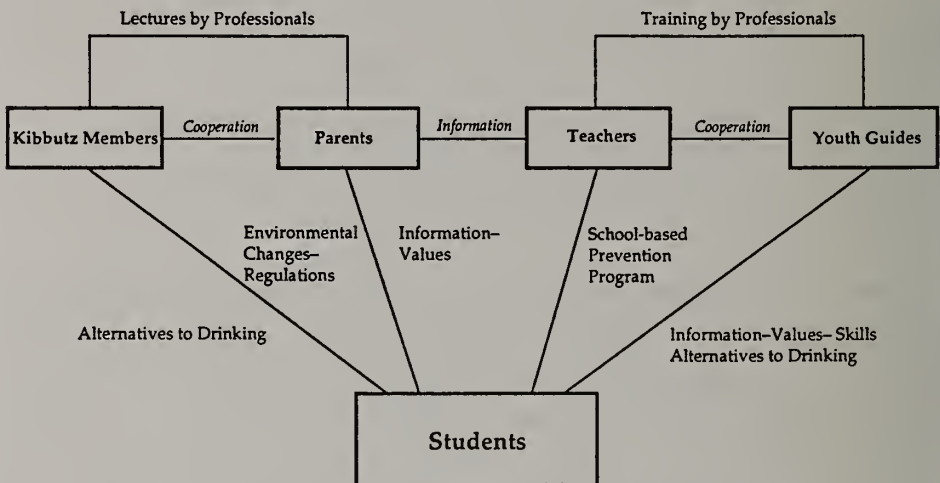
Especially in recent years debts have made the Kibbutzim look for new ways of earning money, with the resulting erosion of the values on which they were built. For instance, in order to earn more money some Kibbutzim have established places of entertainment for city guests. They have built commercial pubs (which can also be seen as an expression of changes in the recreation "style" of Kibbutzim members themselves).

Thus, outside influences, social trends, and particularly the economic situation have destroyed the resurgence of opposing tendencies inherited from the

past. Therefore, drunkenness can be seen in the Kibbutzim among other negative phenomena.

During the first International Research Symposium on Experiences With Community Action Projects for the Prevention of Alcohol Problems in 1989, a paper was presented describing experiences with the Kibbutzim project for the prevention of excessive drinking (Weiss 1990). A Kibbutz Community Model, encompassing education in schools, involvement of parents and other Kibbutzim members, change of local regulations, and provision of alternatives for drinking, was also introduced. This model, illustrated in figure 1, was applied by various Kibbutzim.

Figure 1. Kibbutz Community Model



Nevertheless, during 1989–90 I noticed the emergence of pubs and commercial pubs in the Kibbutzim. Many were ignorant of the need to teach a comprehensive school-based prevention program (Weiss 1988) and implement the community project. I also noted intensive drinking by Kibbutzim youth and decided to try to create in 1990–1991 a new movement for policy changes to prevent excessive drinking in Kibbutzim.

Step 1: The Survey Among Kibbutzim Students

During spring 1990 a survey was conducted in the north of Israel to investigate the alcohol drinking habits of students from the Kibbutzim (Weiss and Moore 1991a) and compare them with those of Jewish students from urban areas (Moore and Weiss, in press 1992) as well as those of Moslem and Druze students (Moore and Weiss 1991). Of the general sample of 2,763 students, 572 subjects were drawn from 11 schools that belong to 62 Kibbutzim. Exactly 435 students were Kibbutzim-born and 137 were outsiders who were living and being educated in the Kibbutzim. The survey was conducted without the

knowledge or approval of the schools' principals in order to prevent any preparation of the students. Teachers in schools cooperated and administered the questionnaires.

Kibbutzim-born youth showed the highest rate of involvement with alcohol among youth in Israel, and the survey revealed a striking difference between rates of alcohol drinking between the Kibbutzim-born group and the Kibbutzim-outsiders group. A picture emerged of an adolescent group in which the large majority has a strong involvement in drinking alcohol at rates resembling drinking prevalence among European youth (for example, adolescents in Britain [Report of Working Group 1987]) and exceeding drinking prevalence among American youth (National Institute on Drug Abuse 1990).

Table 1 shows the percentages of 16- to 18-year-old Jewish female and male respondents who drank beer and distilled spirits (nontraditional beverages) in the previous month.

Table 1. Israeli youth who drank beer and distilled spirits in previous month

Sector	Females			Males		
	<i>n</i>	Beer	Spirits	<i>n</i>	Beer	Spirits
		(%)	(%)		(%)	(%)
Large city	187	16	13	220	41	25
Development town	75	23	11	68	57	38
Kibbutzim-born	178	37	40	200	61	39
Kibbutzim-outsiders	54	22	19	60	40	15

The rates of beer and distilled spirits drinking among Kibbutzim-born females were significantly higher than in the other study groups, that is, large city, development town, and Kibbutzim-outsiders (37 percent versus 16 percent, 23 percent, 22 percent, $\chi^2 = 14.74$, $df = 1$, $p < .001$, and 40 percent versus 13 percent, 11 percent, 19 percent, $\chi^2 = 35.33$, $df = 1$, $p < .001$). It is also evident from table 1 that the highest prevalence of beer drinking is among Kibbutzim-born males (61 percent). Kibbutzim-born males and males from a development town consume more distilled spirits than males from a large city or male Kibbutzim outsiders (39 percent, 38 percent versus 25 percent, 15 percent, respectively, $\chi^2 = 13.21$, $df = 1$, $p < .001$).

Table 2 presents information about drinking frequencies of all male and female Kibbutzim-born and Kibbutzim-outsider respondents.

There were significant differences in the reported frequency of beer drinking between males and females ($\chi^2 = 24.82$, $df = 2$, $p < .01$) as well as between Kibbutzim-born and outsiders ($\chi^2 = 21.01$, $df = 2$, $p < .01$). Further, the latter two also differ in their reported drinking of distilled spirits ($\chi^2 = 29.86$, $df = 2$, $p < .01$).

Youth guides are spending more time with the Kibbutzim-outsiders, who come from urban families of low socioeconomic status or are sent from problem families to be raised in the Kibbutzim. The outsiders are also subjected to more controls on their behavior. Disciplinary problems lead to warnings and even

Table 2. Drinking frequencies of Kibbutzim-born and Kibbutzim outsiders

		Kibbutzim-born		Outsiders	
		Male	Female	Male	Female
Type and Frequency		n=230	n=205	n=74	n=63
		%	%	%	%
Beer	None	42	63	65	79
	Up to 3 times	35	27	31	17
	4 times or more	23	9	4	3
Wine	None	54	60	73	70
	Up to 3 times	37	36	26	28
	4 times or more	8	3	1	2
Distilled spirits	None	60	61	86	83
	Up to 3 times	34	30	8	12
	4 times or more	6	9	4	5

expulsion from the Kibbutz. Usually there are especially strict orders concerning drinking in this group. These facts can explain the gap in frequencies of drinking between the outsiders and the Kibbutzim-born students.

Step 2: The Publicity of the Survey's Results

The Kibbutzim are very sensitive about their image. They believe the public watches them through a magnifying glass. As an outside independent researcher, I could publicize the results. Reports on the findings were published in almost all Israel Hebrew newspapers and in some radio magazines. It was the first time that alcohol drinking rates of Kibbutzim youth had been published. Actually, some Kibbutzim investigators have conducted studies in this area in the Kibbutzim, but the results were not published (Natan 1986).

Step 3: The Astonishment and the Denial

The publication of the survey's findings was actually a new hit added to the list of Kibbutzim problems. The Kibbutzim were amazed. Their authorities responsible for substance abuse prevention refused to accept the findings. The survey was criticized by them as an "unreliable survey conducted by an outsider." However, at the same time, some Kibbutzim members (especially teachers) informed me that the results were only the tip of an iceberg.

At this stage my only response to critics was, "I don't have a drinking problem, the Kibbutzim have. The results serve as their mirror." After the findings were made public, there was a special meeting of the Knesset (Israel parliament) Education Committee at which there was a slight change in the Kibbutzim response. They now claimed that their drinking problem was the same as elsewhere in the country.

In this same period, a special course on substance abuse aimed at Kibbutzim professionals was offered in the north of Israel at a Kibbutz-oriented college. The course did not open due to a lack of participants.

Step 4: The Confession and Acceptance

The Kibbutzim slowly realized that there was no use blaming the study or the researchers and have started to express interest in the findings and their implications. The first stage was an interview and a report in the Kibbutzim newspaper *The Kibbutz*, which encompassed the findings and suggestions for future directions in coping with the problem. However, still, within the framework of this report, the Kibbutzim authorities responsible for substance abuse programs claimed that the findings were exaggerated.

The editor of the Kibbutzim professional journal, *Hachinuh Hameshutaf* (Communal Education—Journal of Educational Thought and Practice in Collective Settlements), invited an article (Weiss and Moore 1991b). The article described the survey, with an emphasis on the Kibbutz Community Model. The article also listed reasons that could explain the high prevalence of alcohol drinking among Kibbutzim-born youth:

- Parents had scant control over the youths' behavior.
- Alcohol drinks are freely available in many youth clubs. The law against selling or giving alcohol to minors is not seriously enforced.
- Young people lack sufficient leisure activities.
- Schools tend to mix components of various programs and "do prevention" during 1 or 2 concentrated days.
- Some of the Kibbutzim lack community projects.

More and more Kibbutzim started to ask for information concerning the survey's findings and methods for coping with alcohol drinking. I lectured to committees of the United Kibbutzim Movement and the Department of Education in Rural Localities in the Ministry of Education and Culture; to at least one-third of the 62 Kibbutzim in the north of Israel (representatives of about 20 Kibbutzim), which belong to Hakibutz Haarzi and the United Kibbutzim Movement; and at the Kibbutz Research Center in Oranim—The School of Education of the Kibbutz Movement-Haifa University. In the center the survey's

findings were compared with the "hidden results" of the Kibbutzim's own investigations. I was surprised to discover that the center's findings were very similar to the survey's findings.

About 20 Kibbutzim expressed their willingness to adopt various components of the Kibbutz Community Model. It was easier to train more teachers and youth guides, to devote more hours to alcohol education in schools, to prohibit the presence of alcohol in youth clubs, to provide alternatives for drinking, and to build parents' and members' workshops than to close the pubs for the adult members, and, especially the commercial pubs established for the general public.

The Present Situation

A drinking problem definitely exists among the Kibbutzim youth, who consume all types of alcohol beverage at rates considerably exceeding those found among other Israeli youth groups. Part of the Kibbutzim try to cope with the problem by adopting parts of the Community Model. However, despite the fact that adults serve as an example for the younger generation, the influences of the urban surroundings and Western culture are strong. Most of the members' pubs are still open, and the commercial ones are profitable enterprises. The Kibbutzim do not want to give up this source of income. The Kibbutzim are unlikely to succeed as long as their efforts are not long-term ones, as long as their "fashionable pubs" are operating, and as long as they do things that are extremely opposite to their ideology, even for the sake of discharging debts. Thus, the renewed adoption of the Community Model is in its initial stage. I hope it will continue to accelerate.

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Alcohol Policy in the Light of Social Changes

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The Polish study Community Responses to Alcohol Problems began in 1987 within the framework of the European project initiated by the European office of the World Health Organization (WHO). The preliminary findings of the study were presented at a meeting on March 11–16, 1989, in Scarborough, Canada (Wald et al. 1990a)

The study was conducted in two communities—Mokotow, a Warsaw district of 400,000 inhabitants, and Sianow, a rural community of 12,000 inhabitants in Koszalin Province in northwest Poland. A survey and interviews with representatives of institutions dealing with alcohol problems were carried out in both localities. The study has confirmed distinct diversity in the perceived rank of alcohol problems. The inhabitants of both communities viewed alcoholism as the country's number one problem; much less frequently they perceived it within their vicinity, in their workplaces, and such. At an institution level, alcohol problems were seen in the narrow perspective of alcoholism. Local experts seemed to detect the problem only in extreme cases requiring immediate action.

Among various institutions, emergency rooms were burdened by alcohol problems to the highest degree. Alcohol-related emergencies consumed about 50 percent of time and energy there; in general hospitals, about 30 percent. Identified alcohol problems were perceived in primary health care as absorbing not more than 5 percent of its potential.

The social response to alcohol problems is a tendency to push the burden onto institutions (for example, the health service and the police) or onto the closest members of the concerned person's family. Spontaneous responses by passers-by or neighbors, who are able to prevent many problems in a simple and uncostly way, are rather rare.

The Polish study also confirmed the existence of a phenomenon called a preventive paradox. Most alcohol problems are caused by normal drinkers, although the individual risk of such problems in the group of heavy drinkers is very high (Kreitman 1986).

The researchers wanted to present the findings of the study to both communities and to work out together a plan of activities, taking local initiatives and ideas into account. Therefore, the findings were presented at several meetings, including the meetings of the national councils, and were published in local papers.

That stage of the study was, at first, planned for 1989, after the parliamentary elections. However, political events took place very fast, and the political atmosphere of the country was unusually animated. Considerable changes, which we shall present below, took place.

Alcohol Issues and Politics

In spring 1990 Poland was preparing for local government elections. We expected the alcohol issue to be made use of in the electoral campaign. The results of the study were presented both to the outgoing authorities (the district national councils), who were mainly connected with the previous system, and to the political groups reaching for power, mainly the so-called Citizens' Committee representing those gathered around Solidarity.

We expected both groups to treat alcohol problems as issues in the electoral campaign, even more so because alcohol issues were treated by Solidarity throughout the preceding decade as an important part of the political struggle. Using alcohol as a political weapon strengthened the favorable moral image of the Solidarity movement. However, those issues were not used in the electoral campaign. When the findings of the study were presented at the last meeting of the Mokotow local council, the council members did not start any discussion of the issue. Most probably this lack of discussion did not mean any particular lack of interest in the issue, but rather was connected with the council's general passiveness. Similarly, no discussion was induced by information given by the head of the police, who talked about a considerable increase of criminality in the district and about a sudden decline in crime detectability (to only 15 percent). No political group taking part in the electoral campaign presented any idea regarding a future alcohol policy. To be able to understand the above processes, presentation of a wider political background is necessary.

Attempts at developing a market economy, initiated by the Communist government, became evident in the second part of the 1980s. Statutes relating to enterprises, adopted at the end of 1988, tried to encourage the development of a market economy and remove the existing obstacles and customs barriers set before private business. The defeat of the Communists in the June 1989 elections and the taking of power by the opposition for the first time since World War II considerably accelerated these processes. The rationing system was lifted in 1989, and intensive actions striving for economic reform were commenced at the beginning of 1990. They mainly consisted of the introduction of an inner convertibility of the Polish zloty, by making pricing free and by freezing wages. Dramatic changes occurred in the economic situation in the country: lines vanished and shops were filled with goods. At the same time, however, real wages and consumption fell drastically. Unemployment grew and the signs of economic recession became visible. The government began a campaign that strived for privatization and demonopolization of the national economy. Actually, apart from trade, privatization covered a relatively small

part of the economy; however, the campaign has had a distinct impact on social attitudes and atmosphere.

The general changes also influenced the sphere of alcohol. After the monopolistic position of the State in alcohol production and trade was limited in 1988 the first private producers of alcohol appeared. The second part of 1989 saw uncontrolled imports of alcoholic beverages by individuals and by private, cooperative, and state-owned firms. There were periods when only imported alcohol was available on the market. As a result of imports, the State Enterprise of Spirits Industry failed to effect its sales plans. In 1990 the customs duties on alcohol were raised considerably and an 800-percent turnover tax was imposed on imported alcohol. However, under the law in force, foreigners were exempt from that tax. Immediately, imports were taken over by foreigners. Imports of unflavored vodka were temporarily forbidden in March 1990. To avoid that ban, huge amounts of vodka with a tiny addition of flavorings, called "gin," were imported. Mass smuggling was often attempted. Uncontrolled sales of alcohol on the Polish market were possible only because the State monopoly for wholesale alcohol was being permanently broken. Only an insignificant amount of liquor went through the Food Wholesale Enterprise vested with such a monopoly. In July 1991 the Supreme Chamber of Supervision presented a report estimating that the State treasury had lost about 170 million dollars because of unpaid customs duties (NIK 1990). That amount constituted about 25 percent of national expenditures for research.

At the same time several other restrictions on alcohol sales were lifted; for instance, the ban on sales of alcohol between 6 a.m. and 1 p.m. and the State monopoly on wholesale trade in alcoholic beverages. Preparations were undertaken to split up the State Enterprise of Spirits Industry and to privatize related enterprises. In other words, alcohol was being treated as any other commodity in the market economy. Controls imposed over alcohol were thought to be a relic of the old, centralized system. The changes related not only to liquors. Several steps were taken to privatize the brewing industry. One should add that the Polish Party of the Friends of Beer, headed by a well-known comedian, was established in 1990. The party took eighth position in parliamentary elections in October 1991 and attained 16 out of 460 places in the Sejm (parliament).

Impact on Consumption

The last two years brought considerable growth in alcoholic beverage consumption in Poland. Because of the uncontrolled imports the Main Office of Statistics abandoned estimating alcohol consumption and shows only data relating to domestic production of alcohol. However, the intensity of alcohol-related problems indicates a growth of consumption. Among such data are those relating to first hospitalizations because of alcoholic psychoses. A 0.98 correlation between consumption of alcohol and rates of hospitalization was

found in an earlier study (Wald et al. 1990b). Previously the highest index was noted in 1980—12.3 per 100,000 inhabitants, when the registered consumption was 8.4 liters per capita. In 1982 the consumption fell to 6.1 liters per capita and the index of hospitalizations fell to 4.7. In 1990 the index of hospitalizations because of alcoholic psychoses reached the level of 13.4—a level never noted before. According to regression analysis that has been applied to estimate alcohol consumption, the level of 9 liters per capita was reached in 1990. Similarly, the number of alcohol-related road accidents grew within the previous 2 years (Moskalewicz 1991).

Despite the growth in alcohol consumption and related problems, there is a constant pressure for liberalization of alcohol policy. Such pressure also exists within local communities. The local authorities require lifting the still-existing limitations on the number of outlets selling alcoholic beverages. It should be noted that the Upbringing in Sobriety and Counteracting Alcoholism Act of 1982 imposed on central authorities the duty to determine the number of such outlets in proportion to the population. It was decided in 1986 that the network of outlets selling beverages containing over 4.5 percent alcohol cannot surpass 30,000 in the whole country. The number of outlets was limited in each province. Together with the progress of privatization of trade and catering, the local governments are flooded with applications for permits for the sale of alcohol. Numerous letters from Province governors and local governments asking that the limits on alcohol-selling outlets be raised are sent to the Ministry of Industry and Trade. The justifications for such applications are very peculiar—they point to a criminogenic nature of such restrictions and to the good influence that new outlets selling alcoholic beverages would have on the labor market. The fact that local government powers have been considerably increased while their budgets are still centralized is certainly one of the motives for such initiatives. Local governments are busy searching for new sources of income.

Despite the fact that the prevalence of alcohol problems has grown, the perception of the problems remains low. Such a situation does not favor any progress in social response. However, we still attempted to stimulate rational alcohol policy in the communities under study.

Prevention Efforts

We were not only seeking the local governments' understanding, we were also trying to increase the sensitivity of the local communities themselves to alcohol problems. A widespread poster campaign was undertaken. Responsible drinking and restraint from consumption in situations of increased risk (e.g., driving, pregnancy) constituted the basic message of the posters. The posters were black and white, and both the form and the message itself drew attention. According to the evaluation study they were noticed by 32 percent of inhabitants who had mostly a positive or neutral opinion (Bralczyk et al. 1990).

Entering into a dialogue on alcohol issues with the government and community met with considerable difficulties. Despite the fact that new people entered the local governments, they still seemed to focus mainly on alcoholism rather than alcohol and its variety of related problems. In such a situation new approaches were suggested to the local governments. Training of social workers was aimed at making them more sensitive to the whole spectrum of alcohol problems and their prevention, rather than trying to solve only the already existing problems. At the same time, an attempt is being made to include alcohol issues in primary health work, particularly in the work of general practitioners, a position to be established in Poland. Training in that field will be associated with the general protection of health.

Primary prevention activities, consisting of work with teachers and students in the course of education, and initiatives aimed at reducing the problems from use of psychoactive substances in schools have been somewhat successful (Ostaszewski 1991).

When characterizing generally the social response to alcohol issues, one should emphasize that interest in prevention actions is becoming relatively weaker—similar to the weaker activity of voluntary associations engaged in prevention, including the biggest of the long-existing organizations: the Polish National Antialcoholic Committee. Activities aimed at the consequences of alcohol abuse are more successful. New clinics, including private ones, are being established. The self-help movement of those stricken with alcohol problems, particularly the Alcoholics Anonymous movement, is developing.

Outlook for the Future

The history of these programs and activities shows very distinctly that social changes may influence the perception of alcohol problems in various ways. The early stages of the development of democracy, with the strong tendency to develop a market economy and a fascination with privatization, favor approaching alcohol in a way similar to that of any other commodity. They also favor social pedagogics that try to make the individual responsible for his or her problems. In such a situation the public health perspective struggles to influence social practice. The expectation that local authorities will be able to cope with alcohol problems better than the central authorities cannot be fulfilled.

In previous years the perception of alcohol problems was shaded by everyday difficulties resulting from a poor economy and shortages in the market. Now the problems are veiled by poverty, unemployment, and the like.

The increase in the number of local alcohol pressure groups is certainly one of the factors amplifying the problem. Decentralization of the economy caused a multiplication of the number of interest groups participating in the alcohol economy. These groups exert a considerable economic and political influence

on local authorities and may effectively reduce the preventive initiatives of the community.

It is not easy to foresee how present trends will develop and how the prevalence of alcohol problems will lead to a social response and encourage bringing alcohol use under control. The parliamentary elections that took place in October 1991 resulted in a considerable split of political forces. Such a disarray will not favor the formation of a strong lobby viewing the alcohol scene from the public health perspective. Alcohol issues have been omitted in the programs of all the political parties except the Polish Party of the Friends of Beer. A more active alcohol policy does not seem possible until a clearer political and social situation emerges.

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Symposium Plenary Discussion

Stig Larsson asked Jacek Moskalewicz to comment on future alcohol policy in Poland. Before the changes 2 years ago, Moskalewicz said, annual alcohol consumption was 7 liters per capita, and it is now estimated at 9 liters. He expects it will reach 11 liters, at which time Poland will follow the example of other countries and explore measures to reduce consumption. In response to another question, he said the increase in consumption probably could be attributed to a sharp decline in the real price of alcohol and its greater availability. While bad economic times might ordinarily lead to a decline in consumption, this does not seem to be the case when prices have declined and alcohol is more available.

Jeff Cameron asked about the structure for alcohol research in Poland. Moskalewicz said he was from a research unit called the Department of Studies on Alcohol and Other Dependencies in an institute of psychiatry in Warsaw. He said the unit devotes most of its efforts to social studies. Previously, he said, 3 percent of all revenues from alcohol were earmarked for research. The research fund has now been abolished. With the coming of the market economy, there has been a huge cut in public expenditures, including those for research. Also, the privatization of medical services leads to the idea that public health is an individual responsibility. For the majority of people who are struggling to meet the basic necessities of life, health is "at the bottom of the value system," he said. Michael Hilton asked if Moskalewicz knew whether other countries in Eastern Europe were having experiences with alcohol similar to those in Poland. Moskalewicz said he believed the other countries are likely to follow Poland's path in this respect.

There was some discussion of Shoshana Weiss's report that she had conducted her survey of Kibbutzim students without the permission of school principals. Weiss said classroom teachers were aware of the extent of drinking problems and assisted in taking the survey. She said she is now embarked on another study without official permission, seeking to find out where people in Kibbutzim seek help when they have a drinking problem.

Strategies for Implementing Local Policy Change

Community Public Policy: A Balanced Alcohol Strategy for Oxford—A Case Study

Shireen Mathrani

Introduction

This paper discusses a 2-year community action research project to develop, implement, and evaluate a communitywide alcohol strategy for the city of Oxford in the United Kingdom. It describes the problems that arose during this process and notes some lessons learned for effective community action in preventing alcohol problems.

Oxford City has a population of approximately 117,000, including 28,000 students. Land within Oxford is scarce and expensive and pressure on the limited housing stock is very high (Oxford Housing Aid Centre 1990). Homelessness is a growing problem. Oxford's image as a city of "dreaming spires" is not strictly accurate as it also has an industrial base. It is estimated that over 10,000 people in Oxford drink alcohol at levels damaging to their health (Oxford City Council 1990). A number of studies (Royal College of General Practitioners 1986) indicated that an estimated 60 deaths in Oxford in 1986 were attributable to alcohol.

Alcohol strategy work was begun in the context of the holistic approach to health put forward by WHO's Healthy Cities—Health for All by the Year 2000 Program. Oxford has been participating in this program since 1986 (Oxford City Council 1988). Also in 1986 the Oxfordshire Health Authority produced its communitywide Policy for the Prevention of Alcohol Problems (Oxfordshire Health Authority 1989). In this setting, the Balanced Alcohol Strategy for Oxford was drafted after wide community consultation. The strategy began to be implemented, and this process evaluated, by an alcohol action officer, jointly appointed by the Oxford City Council and Oxfordshire Health Authority for 2 years until April 1991. This action research project was funded entirely by the Mental Health Foundation, a national charity.

The Strategy

The Balanced Alcohol Strategy for Oxford was the first communitywide alcohol prevention strategy to be adopted by a local government in the United Kingdom, and the only one to have an officer working full time to carry it forward. It addresses the alcohol consumption of the general population rather

than just people with severe alcohol problems (Oxford City Council 1990). It gives priority to improving public awareness of sensible drinking levels and of health risks from alcohol, and aims to be a model of good practice for agencies working together to reduce alcohol-related harm. It makes various recommendations to the city council and to other organizations in Oxford.

Implementing the Strategy

Project initiatives received much media attention and the project as a whole had a training, awareness raising, and publicity component throughout. The strategy advanced on the following four fronts:

An Alcohol Action Network—in Action

The cornerstone of the entire 2-year project was joint work, in particular by the alcohol action officer from the Oxford City Council, the development worker from the Oxfordshire Council on Alcohol and Drug Use (a nongovernmental agency), and the alcohol policy implementation officer from the Oxfordshire Health Authority. These three workers made up a multidisciplinary team that initiated much of the action arising out of the strategy. They took every opportunity to involve anyone interested in alcohol work, particularly if they were able to raise the issue of alcohol and public health in their own organizations and were senior enough to influence policy. Basing the alcohol action officer in the Oxford City Council's Health Promotion team meant that she also had the backup of a sound ideological and practical base and a supportive environment (Mathrani 1991).

Contacts were formalized by setting up an Alcohol Forum, representing a wide range of statutory and nonstatutory organizations in the city. The forum was chaired by a city councillor and serviced by the alcohol action officer. It was effective in achieving relevant policy changes, such as a stricter code on alcohol advertising at cinema showings aimed at children and a ban on the sale of alcohol from a hospital shop. It ensured that work was not carried out in isolation and helped to make alcohol prevention more acceptable and mainstream.

The Balanced Alcohol Strategy as Oxford City Council Policy

Oxford City Council comprises 45 elected members (the councillors) and is Labor led. Once the alcohol strategy was finalized it went before its parent council committee, the Health and Environmental Protection Committee, for approval. Despite extensive consultation, the strategy was not approved but was referred to ten other council committees for consideration. At these committees, resolutions were passed outlining agreed areas of work. The strategy was then reconsidered by the Health and Environmental Protection Committee, received positively, and recommended to the full council to be adopted as council policy. It was then debated by the full council and adopted by only one vote: 16–15. The closeness of the vote illustrates the controversial and sensitive nature of alcohol strategy work.

Some of the following agreed policy changes have begun to be put into action by various council committees:

- *Personnel Committee*—To set up a working party in order to extend, publicize, and implement the council's policy on alcohol in the workplace.
- *Estates Committee*—To prohibit the advertising of alcoholic beverages (except low-alcohol or alcohol-free brands) on city council sites.
- *Recreation and Amenities Committee*—To recognize that many of the recreation and community facilities provided by the committee include licensed bars and that the committee therefore has a particularly important role to play in pursuing the Balanced Alcohol Strategy. To encourage breweries to advertise low-alcohol and alcohol-free drinks more intensively and, where the council had control over pricing, to lower the prices of these drinks.
- *Health and Environmental Protection Committee*—To approach the county council in its capacity of Social Services and Education Authority; the university, polytechnic, College of Further Education, and other colleges; the police, the clerk to the Oxford Magistrates, the local judiciary, the Probation Service, and the Prison Service; and the clerk to the Oxford Licensing Justices in order to encourage joint action on the prevention of alcohol problems.

To inform all voluntary and community organizations in the city of the Balanced Alcohol Strategy and to involve them in its implementation.

Working with council departments

Along with preliminary work with the Personnel Department on the council's policy regarding alcohol in the workplace was a campaign run by the Alcohol Forum objecting to the building of a bar in the Town Hall, which would be open during working hours. The forum felt that rather than increasing the availability of alcohol at work, the council should decisively tackle alcohol misuse in its own workplace. The Town Hall Bar became a test case of inhouse commitment to the Balanced Alcohol Strategy. This campaign divided local politicians, particularly on the issue of personal choice versus the discouragement of drinking at work. It highlighted the difficulties of developing policies on alcohol in the workplace, employers' bars, and lunchtime drinking. Eventually the proposal for a bar was deferred, not because of the forum's campaign, but because it was considered too costly to build.

A very effective working relationship was established with the Community Recreation section of the council's Recreation Department. This relationship led to joint work at health and recreation events and to a major community project, Welcome to LA, piloted at one of Oxford's community centers, as described next.

A Community Program of Action on Alcohol

Welcome to LA—Northway Community Centre Alcohol Awareness Week

This project aimed to use a community action approach to raise public interest in, and awareness of, alcohol and sensible drinking, in an entertaining way, that empowered the community and used the media.

Oxford has 21 community centers of which 11 have bars. They are cheaper places to drink than pubs and usually have more of a family atmosphere. In Oxford they have rarely been used for health promotion initiatives. Northway Community Centre has around 800 members drawn from a catchment area of 2,500 households.

Welcome to LA week was organized jointly by Oxford City Council's Health Promotion and Recreation sections in conjunction with the center itself. The week and its message of sensible drinking were well publicized and sponsored by local firms. The clubs meeting that week at Northway took part in low- and alcohol-free tasting sessions. The center bar hosted a display on healthier drinking all week, low-alcohol happy hours on most evenings, and a health and fitness night on Friday. A special event billed as Gala Night was held on Saturday. Around 200 people attended and bar takings were £120 higher than on an average Saturday night! The highlight of Gala Night was a team health quiz of 50 questions; the majority of questions were on alcohol and there were others on fitness, home safety, acquired immunodeficiency syndrome and human immunodeficiency virus, smoking, and diet. Led by a professional quizmaster, eight teams of four, all center users and drawn from existing clubs, took part in a very competitive and entertaining atmosphere. It was clear that the participants had studied the health material that had been available in the bar all week. Much favorable feedback was received from the center organizers and users.

The week was very successful in that it raised interest in the subject of alcohol and health while reaching local people in their own leisure surroundings. It proved that an alcohol action project can be located successfully in a bar.

This project was intended to be repeated in other interested community centers. Unfortunately, this was not possible because funding for alcohol prevention work came to an end and further grants could not be found without a funding commitment from the council itself.

Problems

The lack of political will to see the prevention of alcohol problems as an important goal and the lack of a working budget were major stumbling blocks. The fact that many community groups, local authorities, and other organizations around the country and abroad expressed interest in Oxford's pioneering

alcohol prevention work did not seem to convince local politicians.

The following were common objections to the strategy:

"The strategy restricts individual choice and interferes with private behaviour."

"It is not the local authority's role to become involved in health promotion or alcohol prevention work. These issues should be left to the health service."

"Alcohol does not cause problems except to that tiny minority of drinkers who are alcoholics. Thus, such a strategy is irrelevant to the community at large."

"The strategy is too wide-ranging and detailed. It requires too many resources and too much staff time to implement."

"The strategy attacks values at the heart of British culture: the culture of going to the pub."

"Such a strategy at the local level is useless without national support, funding, and coordination."

"The advice and education aspects of the strategy are acceptable, but the setting of standards or the changing of practices to discourage alcohol consumption is not."

"The provision of services like a detoxification centre for alcohol-dependent people is important. The strategy should concentrate on these aspects, not the wider community issues."

Overview: Getting the Strategy Adopted

Hindsight shows that the Balanced Alcohol Strategy for Oxford was very ambitious. The document could have been phrased in general terms that steered clear of controversy. Instead, it tackled the subject head-on and included the contentious issues of drinking in the workplace, alcohol advertising, and funding and sponsorship from the alcohol industry. Adoption of the strategy was achieved with the help of those council members who were supportive and others from inside and outside the council who believed that local authorities did have an important role to play in health promotion.

The passage of the strategy through all the council committees was the best possible course of action. This process initiated a public discussion on issues relating to alcohol, public health, and the responsibilities of a local authority for the first time. For example, was a change in sponsorship policy needed? Should a planning policy be drafted specifically for licensed premises? Thus, with a readiness to take on even controversial issues much can be achieved.

Lessons Learned

Alcohol as it relates to public health is a very sensitive and controversial subject. Reactions to it are not predictable along political party lines. People are poorly informed about alcohol and may have never seriously considered the subject before. Furthermore, they often feel threatened by issues around alcohol misuse, whether because of the social acceptability of drinking, lack of knowledge, personal drinking habits, or vested interests. Negative reactions to alcohol action can arise anywhere and with anyone, including health professionals.

The image of the alcohol program and its workers is extremely important. If seen as prohibitionist, the alcohol strategy will founder. The strategy must be presented in a positive light—giving information, improving awareness, and enabling people to make decisions that will improve their health and quality of life.

Extensive consultation is needed to try and reach agreement before a local alcohol strategy is put forward for adoption. Consensus is much easier to achieve if a limited number of realistic objectives are set and if the strategy is prepared in the context of other health and community policies, with an emphasis on local data. The agency producing the alcohol strategy should make a distinction between goals set for itself and recommendations to other bodies. As proposer of the strategy, the agency should set an example to other organizations.

Discussion and Conclusions

This exciting 2-year project went some way toward achieving effective community action on the prevention of alcohol problems. It is disappointing to report that due to a lack of further funding, Oxford City Council no longer employs an alcohol action officer and the work resulting from the adoption of the alcohol strategy cannot be continued. The rest of the council's Health Promotion team has been able to take on only a limited amount of alcohol prevention work.

This project highlights many issues that were discussed at the Second International Research Symposium on Experiences with Community Action Projects for the Prevention of Alcohol and Other Drug Problems. One such issue is the necessity for process evaluation. This paper has attempted to describe the process of implementing a communitywide alcohol strategy in Oxford. It is vital for community organizers, researchers, and the community itself to document the process of the project, not just the outcome, and to do so in media other than specialist journals. For example, this particular project can be written up in alcohol, health promotion, policy, recreation, municipal, or community action journals and should be communicated in lay terms that both politicians and the public can understand, as stressed by Jim Anderson at the conference.

Another issue that is most relevant to the work in Oxford is the concept of community sustainability. In this project, funding came to an end, the post was cut, and little action has been sustained: infrequent meetings of the Alcohol Forum and limited initiatives for the yearly Drinkwise Day. Are there ways community action on alcohol can be sustained when funding runs out? Perhaps such action is sustainable only when ordinary citizens and community members, rather than the professional community or health workers, have initiated it.

As proposed by Robin Room, there are at least three models of action on the prevention of alcohol problems: the harm reduction model, the health promotion model, and the "sensible drinking" model, which concentrate on long-term implications. The work in Oxford fits the last model, which targets the general population of average "social drinkers." This model is the most politically unpalatable and contentious of the three and the most difficult to implement, as evidenced by this paper. As noted by Room, it is much harder to tackle the male and middle-aged drinking environment of the Town Hall Bar than, for example, to concentrate on educational programs for young people. This fact comes back to another point expressed at the conference, the need to be aware of the distinction between who owns and controls the community and who is the community.

Sally Casswell pointed out that policymaking goes on regardless of whether community action research exists, so possibly the most effective model of community action on alcohol uses existing policy structures and attempts to modify existing policies. We tried to do this in Oxford and laid foundations for work that may be taken up by local authorities in other areas of the country.

The case study of Oxford shows that a community movement toward Health for All can use the structure of local government in Britain to its advantage and achieve policy changes that should lead to increased public awareness about alcohol and a reduction in alcohol-related harms.

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The California Community Planning Demonstration Project: Experiences in Planning for Prevention of Alcohol Problems in Four Municipalities

Friedner D. Wittman and Fran Biderman

The Institute for the Study of Social Change (ISSC) Community Planning Demonstration Project, currently under way in four California communities, provides a laboratory for studies of community-level environmental planning to prevent problems related to alcohol availability. On the basis of years of observing community-level experiences with alcohol availability, this project explores the application and dissemination of a community planning approach aimed specifically at preventing availability-related problems. This paper summarizes progress to date as the project nears its midpoint.

Most alcohol-related damage in the United States comes from interactions between drinkers and their surrounding social-physical environments rather than from the personal or familial pathologies of individual alcoholics (Moore and Gerstein 1981). Alcohol environments—the everyday settings and circumstances in which people obtain and drink alcohol—contribute to the incidence and prevalence of alcohol problems (Room 1980, 1984; Hooper 1983; MacDonald and Whitehead 1983; Single and Storm 1985). Thus community-level efforts to prevent these problems can be approached from an environmental-change perspective: Identify the settings and circumstances in which problematic drinking occurs, and then modify those problematic environments in order to reduce or prevent the problems (Room 1984; Wittman and Shane 1987b).

Environmental designers ask three basic questions of any design or re-design project: What is the basic design problem? Who decides the design solution? Are we satisfied that the solution solves the problem? (Schon 1983) In terms of the Demonstration Project:

- What actions can be taken at the community level to reduce or prevent harm done to the community's health and well-being by problematic alcohol environments?

- How does the design process resolve the many claims (rights and interests) held by occupants, owners, and authorities with jurisdiction over the environment?

- What are the actual results of prevention-oriented change initiatives, and do these initiatives have the desired effects?

Project Design

Establish a Municipal-Level Planning Process That Can Modify Alcohol Availability To Prevent Specific Alcohol-Related Problems

Four broad areas of interest drive the Demonstration Project to work at the municipal level.

Clarify the Relationships Between Alcohol Availability and Alcohol Problems

The project seeks to develop a workable general model of the relationship between alcohol availability and alcohol problems at the community level. This model should be useful both for describing the actual relationships in place and for acting on those relationships to reduce alcohol problems.

In order to intervene effectively in problem drinking, planners need to know precisely in the community where, when, in what settings, and under what circumstances drinking is or may become problematic. Once the connection is known between community environments and alcohol problems, planners can seek to reduce the problems by modifying the problematic environments. Prevention interventions can be undertaken to change the use, design, operation, location, and density of those environments.

Interventions applied to three forms of local alcohol availability encompass almost all types of alcohol problems encountered in everyday life at the local level.

Retail availability provides alcoholic beverages through on-premise and off-premise sales outlets, and through special events that include the sale of alcohol. Typically, about 25 percent of a city's retail outlets sell alcoholic beverages, and between 10 percent and 15 percent of the city's total taxable retail sales may be attributed to sale of alcoholic beverages (Wittman and Shane 1987b: p. 5).

Public availability allows sale and/or use of alcohol at public places (parks, beaches, streets, parking lots, civic facilities such as armories and stadiums) and at public events (holiday celebrations, dedications, street fairs, art shows, sports events). In California alcohol availability in public places is determined by local legislatures rather than by the State, except for highways and State-owned property.

Social availability includes all customary drinking patterns and practices in the community. Most social availability is not problematic, but some forms of availability promote drunkenness and dangerous consequences. Examples are teenage keg parties; drinking and driving; drinking at work; and drinking as part of domestic quarrels. Most communities do not have very effective mechanisms for airing such problematic drinking customs when the customs are widespread or traditional.

Focus on the Municipal Level for Development of Local Prevention Initiatives

Federal and State governments are increasingly placing the burden on localities to develop their own prevention strategies and programs. As it happens, municipalities have many resources that can be locally organized to reduce or prevent problems related to the community's retail, public, and social alcohol environments. Cities can use their powers both independently and in conjunction with the State (Wittman and Shane 1987a). A major concern of the ISSC project is to articulate these powers clearly and in a form that encourages their application by local agencies and organizations. See figure 1, drawn from Wittman and Biderman 1990.

These resources are strongest when used in combination and in mutually reinforcing ways and are focused on specific alcohol problems. The task for planners is to mobilize prevention initiatives that concentrate multiple prevention strategies on specific alcohol problem environments.

Community agencies and organizations typically apply their resources through a quasi-rational five-step planning process. This process applies to a broad range of the community's social, health, and economic problems.

- *Accept the need for local action.*—Local agencies and organizations

Figure 1. Community-Level Prevention Strategies

<i>Environment</i>	<i>Source of Problems</i>	<i>Environmental Strategies</i>
Retail outlets	Land-use patterns Business practices	Alcohol-free events
Public places	Parks Sidewalks Beaches Stadiums	Alcohol-safe events Environmental design Local public ordinances
Social environment	Schools Workplaces Neighborhoods Entertainment Churches Holidays Special events Parties Fundraisers	Organizational policies Planning/zoning ordinances Public information Voluntary agreements Work with Alcoholic Beverage Control agency

acknowledge that the problems need attention, and agree to work on them together.

- *Form a local planning group committed to action.*—The community's agencies and organizations form a planning group that includes a coalition of those concerned about the problem's impact on their health, social well-being, and economic security.

- *Commence a planning process that assesses precisely where specific problems are in the community and identifies change strategies for dealing with the problems.*

- *Obtain and organize the resources required to make the needed changes and agree on a course of action for use of the resources.*—Both local and State resources are involved; modest additional resources can often do much to apply powerful local resources that already exist.

- *Implement the course of action through local agencies and organizations.*—Institutionalize the action locally where permanent changes and continuing efforts are required.

Assist Municipal-Level Organizing to Initiate Community-Level Prevention Planning

Efforts to implement a community-level environmental approach to prevention often seem to go against the grain of what local agencies and community groups think should be done about alcoholism and alcohol problems. Communities need help in three areas to organize local prevention planning efforts to change alcohol-problem environments.

First, most communities are not generally familiar with the concept that alcohol availability in its several local forms is a significant source of alcohol problems. Most communities do not realize that they have substantial powers of their own to recast alcohol availability into a public health framework. Many do not understand that they are *not* required to defer to the commercial prerogatives of the alcoholic beverage industry.

Second, a communitywide effort to address alcohol problems requires extensive coordination of agencies and organizations because all sectors of the community are affected by alcohol problems. This coordination means that a fully developed planning initiative will include public agencies, churches, schools, neighborhoods, businesses, industry, voluntary associations, and the like. The planning effort needs to be integrated *within* community institutions, so that each sector uses its own skills and resources to address alcohol problems. The effort also needs to be integrated *across* institutions, so that combinations of efforts can be applied to complex, multifaceted alcohol problems.

Third, reliable planning information is needed to describe problematic settings and situations in the community and to evaluate changes to the environments of alcohol availability. Unfortunately, most local recordkeeping systems suppress information about alcohol-related problems and underreport the extent to which alcohol is problematic for the reporting agency or organization. Special efforts must be made to collect local alcohol-problem information that is useful for prevention planning.

A planning consultant who specializes in prevention issues can do much to help the community overcome these barriers to change. Ideally, local planning groups might spontaneously address issues of knowledge, coordination, and information in order to act on alcohol problems. In practice, the demands for changes in common perceptions and changes in longstanding habits of thinking, and the hard work of organizing are generally too difficult for a self-organizing group working at the local level, particularly a group working primarily on a voluntary basis. However, local groups do respond well to formal community organizing assistance and will accept help from trained community organizers, provided the local groups are properly approached and participate actively in the change process (Mayer 1984; Wittman 1990; see also discussion below).

Develop a Statewide Prevention Planning Demonstration Project of Value to Many Municipalities

The Demonstration Project seeks to develop a systematic planning approach that can be documented and evaluated so that its experiences can be disseminated to approximately 490 California cities. The project is being developed with an eye to replicability and affordability for local communities, and is trying to reinforce the propensities of localities, especially municipalities, to share information and techniques with each other.

Fundamentally, the ISSC project explores the creation of effective working relationships between a local planning group and experienced professional planners. The basic premise for the relationship is the transfer of knowledge and expertise from the planners to the local planning group.

Brief Project History

Pilot Project

The Community Planning Demonstration Project grew out of efforts to disseminate a planning handbook intended to be a self-directed guide for local groups interested in carrying out their own efforts to prevent problems related to alcohol availability (*Manual for Community Planning to Prevent Problems of Alcohol Availability*, funded by the California Department of Alcohol and Drug Programs, Wittman and Shane 1987b).

A four-city pilot study to disseminate the *Manual* provided lessons on the gap between the printed information in a manual and the information's actual use at the local level. Simple distribution and introductory lectures on the *Manual* were, with a few notable exceptions, not sufficient to secure its adoption at the community level. Instead, we concluded from the pilot study that (1) municipalities need to decide through their own leadership to work with the *Manual*; (2) public agencies and community groups need extensive education about the complex link between alcohol availability and alcohol problems and about community-level prevention planning; (3) continuing technical assistance needs to be provided directly, continuously, and on site to help local agencies and groups make effective use of their own local resources; and (4) 12 months is too brief a period to implement community-level environmental changes.

We also made several observations about working relationships between a planning consultant and a planning group for one of the four cities. This city, which received almost monthly consulting visits, showed that (1) local agencies and community groups themselves can take the initiative to work together, provided they have clear ideas of where they are headed and are provided with technical assistance to reach their objectives, and (2) a consultant can facilitate local initiative to develop apt, creative ideas for the solution of alcohol availability-related problems particular to the needs of the specific community.

Design of the Current Project

Pilot project experiences led directly to the design of the current 3-year study, which at this writing is 5 months into its second year. The following design features were particularly important to encourage formation of community planning groups in each of the four demonstration cities.

- *A selection process designed to secure interest and participation of a motivated community as the site for the Demonstration Project.*—The communities selected to participate in the project were those whose mayors or city managers accepted ISSC's invitation to participate in the project. Support from local officials has been essential for initial organizing efforts, logistical support, and project leadership.

- *A formal planning group in each community.*—The first order of business in each community following initial acceptance of the project was formation of a local planning group, which represents the community's many institutional sectors concerned about alcohol and other drug problems. The ISSC planners suggest basic functions for the planning group and the roles of its leadership in the *Blue Book* (Biderman and Wittman 1990), a planning information guide furnished to each member of the planning group as a complement to the *Manual*.

- *A basic planning process that the planning group will follow.*—The basic planning process consists of a three-phase effort intended to culminate in specific changes for problematic alcohol environments. An assessment phase, commitment of resources phase, and implementation phase, each nominally lasting 1 year, are outlined in the *Blue Book*. Specific steps and subobjectives are suggested by ISSC for each phase, but are conducted by the planning group and are subject to local interpretation and styles of action for each of the four planning groups. Thus each planning group “owns the process” even though the basic outline for the project is given by ISSC.

- *A working partnership between the ISSC project team and the local planning group.*—Perhaps the most intriguing and most significant part of the project is the relationship between the ISSC project team and each of the four cities’ local planning groups. The ISSC team consists of a half-time director responsible for strategic planning and project oversight, a 90-percent coordinator responsible for day-to-day operations and training and supervision of community organizers, a 60-percent monitor who documents project activities and reports on project processes, and a 20-percent evaluator who is responsible for the design of the project’s data collection system, project documentation, and analysis of the outcomes of environmental change initiatives. Half-time secretary and research assistant positions complete the project team.

The ISSC team is a source of structure, information, technical assistance on prevention strategies and initiatives, consultation on organizing strategies, and assistance with meetings. The ISSC team also can provide ideas, comment, and critiques for local planning group efforts. This backup encourages each city’s planning group to take the initiative to do all that is necessary to identify and to act on availability-related problems in the community. The presence of the ISSC planning team assists the planning group, first, in adopting what for many is an unfamiliar prevention goal (reduce alcohol-related problems by changing problematic alcohol environments) and, second, in focusing efforts to achieve that goal.

The ISSC team is careful *not* to take on specific planning and decisionmaking duties for the community itself; these are the responsibility of the planning group. The ISSC team has no vote, and the planning group is free to reject ISSC’s comments or advice.

- *Comparison of planning experiences in the four communities.*—The project was originally designed as a 2 x 2 comparison study of community experiences with minimal and enhanced levels of professional planning support. The four project cities were selected to be as similar to each other as possible to assist with comparisons. Two “minimal” communities were to receive three introductory presentations on the *Manual* and followup technical assistance only if the project initiated a formal request from ISSC. The other two “enhanced” communities were to receive a half-time community organizer who is paid and trained by ISSC and jointly supervised by ISSC and the local planning group

chair. The enhanced communities were also to receive ongoing consultation and technical assistance freely, as needed, with ISSC suggesting topic areas in which help would be offered.

- *Continuous project monitoring and evaluation.*—Finally, the Demonstration Project has a formal process-monitoring component, consisting of monthly telephone contacts with selected members of the planning group in each community and formal debriefings of the project director and project coordinator. Additionally, as individual interventions are developed, formal outcome measures will be added to track the results of the interventions. Monitoring and evaluation components constitute 25 percent of ISSC's project budget.

Current Status of the Project

Generally, the project is proceeding as originally envisaged. Currently, all four project cities are making progress on the assessment phase of the general planning process. This phase both reveals information about problematic alcohol environments in the community and encourages interest and expanded community participation through the data-gathering and analysis process. The assessment process will culminate in a community forum, at which time community groups, local agencies, and interested citizens will review the assessment's problem findings. Out of this review will come the formation of specific task groups directed toward redesign or elimination of specific alcohol problem environments.

Progress on the Original Time Line

Two notable deviations from original expectations have occurred so far. First, the time line for start-up and assessment activities has had to be extended. The project is approximately 6 months behind its original schedule, which allowed 1 year each for assessment, commitment of resources, and implementation phases. Four to 6 additional months were required for community entree and basic familiarization with the project. Approximately 4 to 6 months of the assessment phase are needed to build up the planning group (which meets monthly) to the point of being able to support the project's concepts, strategies, and goals in the community at large.

Modification of the Project's Experimental Design

The second deviation from expectations has been reversion from a 2 x 2 comparison to a four-city case study. If ISSC had reverted to the planned "minimal" assistance format as scheduled, we had considerable evidence that the planning groups in the minimal cities would have stopped meeting and the project would have died. Accordingly, the ISSC project director decided to make ISSC support available to all four cities on the same basis as for the enhanced cities.

Observations on the Planning Process in Mid-Stream

Observation 1. *Care must be taken to ensure that participants in the local planning process thoroughly understand the environmental planning perspective.* Time taken to do this at the outset is repaid many times over when the project's central concepts are understood and accepted in terms of the participants' own beliefs and experiences.

Observation 2. *A community-level planning initiative can be organized at the local level through a citywide local prevention planning group.* The planning groups "owns" the project by taking the initiative to identify problems and to act on its own.

Observation 3. *Planning collaboration can combine technical-professional resources with local concern about alcohol problems to activate the planning process.* Collaboration between ISSC and local planning groups should provide a vehicle that encourages, rather than inhibits, local styles and local invention in the development of the community's prevention initiatives.

Observation 4. *Some tension is healthy among planning group members to encourage the planning process to stimulate planning activity.* Local efforts to change problematic alcohol environments are highly unlikely to occur unless dissatisfaction surfaces over current alcohol environments. The assessment phase articulates this dissatisfaction by eliciting comment both on problematic alcohol environments and community responses to them, and by providing opportunity for the planning group to work out the implications for prevention.

Observation 5. *The local planning process requires planning information that is readily available to local agencies and organizations and that is adequate to describe specific problems related to alcohol availability in the particular community.* Official recordkeeping systems in local agencies and organizations maintain a discreet conspiracy of silence about everyday institutional contacts with alcohol problems (Shane and Cherry 1987; Harding and Wittman 1990). Local prevention planning projects accordingly must construct their own data systems. The key informant interview approach of the ISSC project uses a qualitative approach, although ordinal and numerical relationships in the data are identified. A complementary quantitative approach to communitywide problem assessment also should be developed, based on improved reporting of alcohol involvement in official activities of the community's various agencies such as police departments, hospitals, and schools. One such system, ASIPS (Alcohol-Sensitive Information and Planning System), has already been developed and pilot tested (Wittman and Harding 1991).

Observation 6. *Local planning activity needs staff time to provide adequate followthrough for planning decisions.* The ISSC project suggests strongly that a paid half-time community organizer is essential to timely and thorough movement through the planning process for a project of this magnitude.

Observation 7. *The entire planning and intervention process should be held accountable for making observable reductions in specific availability-related alcohol problems.* Talk leads to action when the following occur:

- Conceptual and perceptual shifts are stimulated to aid local groups and agencies to realize that apparently immutable environments of problematic alcohol availability can, in fact, be changed through the use of local powers and resources.
- Selective alliances are formed for particular change initiatives.
- Specificity is encouraged in identifying precisely the problems associated with particular environments.
- Opportunism is acceptable in the pursuit of environmental change opportunities. Taking advantage of "targets of opportunity" includes responding to tragic events that galvanize the community or to other unexpected circumstances that come to light as the project proceeds.

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Symposium Plenary Discussion

Robin Room said the Oxford project had elements of a harm reduction model but also reflected the British interest, led mainly by medical doctors, in establishing limits on amounts of alcohol being consumed on an occasion. He would call this more of a risk reduction model, driven by considerations of risks of intoxication rather than risks to health. The Alberta project suggested a health promotion model, urging young people to consider that delayed gratification would pay off for them in the long run. "It's interesting to see the different political face of these different models," he said. "The single-minded focus on drinking and driving is certainly something the industry has become comfortable with. I wonder whether they wouldn't be equally comfortable with a sort of generalized health promotion approach." He added that the Oxford project

may have been the "bravest" approach because it tackled heavy drinking, which hit the local council "close to home" and made it somewhat unpalatable politically.

Fried Wittman said the project he described might sound like a harm reduction model and it was seen in a very positive light at the local level. "Local agencies and organizations are able to use their local resources to manage alcohol environments in a positive sort of way, so people can have a drink and not get into trouble.... We deliberately stayed away from questions of how people should drink in a positive way. There's no end of people telling them how to do that—starting with the beverage industry."

Louis Gliksman noted that in Wittman's project, the highest elected official, the mayor, in each community was contacted as a sort of gatekeeper. He questioned why getting this approval was considered necessary. Wittman said going to the mayors was part of an effort to conduct the programs in communities that had already been mobilized and were positively disposed toward prevention planning. "The aim was to find cities that were large enough to be interesting but small enough to be workable," he said.

Anders Romelsjö recalled that some 10 years ago in Sweden there was great interest in alcohol issues. The model for prevention was a total consumption model that combined health promotion and harm reduction. The effort included recommendations by physicians that people refrain from drinking alcohol or drink only wine, and in some cases local officials set an example by refraining from drinking. These programs lasted 3 or 4 years and, to his knowledge, none of them worked very well. Shireen Mathrani said the experience in Oxford indicated that local officials found it awkward to function as role models in connection with prevention efforts.

Wittman said the local groups in his programs seemed to be more interested in high-risk and high-visibility drinking situations rather than high-volume drinking by individuals as a health issue. There would be an effort, of course, to provide for drinking in settings that do not encourage drinking to the point of intoxication. Geoffrey Hunt discussed the enforcement of a "kegger" ordinance in a northern California county, which gives police access to a private home if they believe five or more young people are drinking on the premises. While the ordinance is supported in affluent parts of the county, it is resisted in areas of lower socioeconomic status out of fear that it would be used for police harassment. This example shows how legislation pushed in the alcohol and drug arena can raise issues of threats to civil liberties.

Jan Howard, returning to the question of industry support of prevention measures, observed that Loran Archer of NIAAA has been doing some research on numbers of drinks as a health issue. Archer has pointed out that while the industry seems interested in promoting the idea that two drinks a day on average might be beneficial in preventing heart disease, it would be detrimen-

tal to industry profits if all those who now drink more than two drinks a day were to reduce their intake to two. "For that reason it might not be in the best interests of the industry, profitwise, to take on the health issue," Howard said. She added that consumers do appear to be sensitive to health issues. Recently a media report that consumption of red wine could reduce heart disease was followed by a sharp jump in sales.

Tim Stockwell commented that if there are going to be harm reduction programs it will be necessary to give people information about "safe" levels of alcohol consumption. "It would worry me if we leave it to the industry to decide what responsible drinking is.... Typically, if you let the brewers do it, they're very generous." He wondered if preventionists in the United States and Canada are reluctant to discuss safe levels of drinking because they actually want to see people be abstinent. Wittman responded that Americans do deal with this issue, in a way, because the underlying value of prevention in the United States is for people not to get drunk. "We're not taking on don't-drink-too-much head-on; what we're saying is, 'Let's set up community alcohol environments where people don't get drunk.'" Tom Greenfield observed that safe levels of drinking may differ from one individual to another, and it would be difficult to prescribe a safe level that would apply to everyone. Jim Anderson discussed the same difficulty and said that his agency in Canada responds to inquiries with advice that people either drink in moderation or not drink at all, and that moderation means no more than 14 drinks per week and no more than 4 drinks on any one occasion.

Ron Douglas said he found this discussion "a bit disturbing" because it seemed to force people to choose one strategy over another. "I'm not sure we should be heading in that direction," he said, noting that models or strategies were being discussed without clear agreement on what they mean. For instance, he believed that "health promotion" encompassed risk avoidance, risk reduction, and health enhancement strategies that worked in combination and thus addressed a number of risk behaviors that could be identified with certain consumption levels. "People could be given very specific information that they could incorporate into their everyday lifestyles."

Policy Initiatives and Public Health Research: Commentary and Reflections on the Day

Robert I. Reynolds

It's quite a challenge to wrap up the opening day, especially when you were looking forward to hearing Bob Denniston. Unfortunately, Bob Denniston is home ill, so you get Bob Reynolds instead. To put a little perspective on my remarks, I was privileged to be at the Scarborough conference. At that point I was the health deputy for alcohol services for San Diego County, but after Scarborough I came home, quit my job, and went full time into alcohol policy advocacy. As I can attest, there are certain dangers about conferences that ask us to reflect on our life's work. I have the distinction of having been the campaign director for the California Alcohol Tax Initiative campaign. This campaign qualified for the ballot, but lost at the polls. In other words, I'm the gentleman who began a campaign with public support at 80 percent, but on election day managed to win support of only 39 percent of the voters. So if you also want to learn how to lose 41 percentage points in public support, come talk to me. In fact, we have a video case study of that campaign—our effort to reduce the lessons of that campaign into 27 minutes of video will have its very first showing anywhere tomorrow at 5 o'clock. Of course I am also very tempered by Roberta Ferrence's comments today that successful campaigns need a champion. I think that campaigns like the California Alcohol Tax Initiative need a host of champions!

I have very vivid and pleasant memories of Scarborough, both because of personal friendships I made and insights I gained through the papers that were presented. In 20-some years in the alcohol field, I've been to many, many conferences, and it's rare to be able to reflect back on a conference so rewarding for individual insights and new friendships. It's great to see many of those friends again, and to exchange our insights and experiences in the second of what I hope will be a recurring series of conferences.

Norman Giesbrecht's keynote address presented a wealth of material in a succinct way. The paper speaks both of the tension that exists between researchers and those in the advocacy and action area, as well as the tension between process and outcome evaluation and how difficult it is to balance these interests. I thought his comment that we don't have pilot projects for parenthood was particularly insightful. We don't have pilot projects for community prevention activities, either. Our projects influence people's lives. This process is humbling, which makes it all the more critical that we take a look at our work, try to understand what it is we've done, and convey that information to those who come after.

I was really taken by Norman's overview of typologies and his summary of advances in the field and of the challenges and opportunities before us. It's

difficult sometimes to think about things that have changed in just 3 years, and yet in this field I think there have been some very significant changes. Norm commented on one of these—the link between alcohol and tobacco advocacy interests. Roberta Ferrence spoke to this development, and that link is a very important change, I think, in our field.

After the first couple of papers I remarked to Robin Room that we left Scarborough after a long discussion of what is community, and here we are back discussing what is community. Robin pointed out rightly that this meeting is a continuing discussion among friends, and it's only appropriate that we come back and pick up where we left off. A number of the papers today pointed out how important it is for us to be able to define our level of community, whether it be policymakers, general citizens, or media spokespersons. The definition of community is critical to an assessment of our strategies and our selection of campaign formats.

I look back over quite a few years now and see some shifts in the focus of prevention efforts. We used to focus simply on changes in individuals, primarily in educational settings. We haven't had much discussion of that today, and that reflects the limited impact of such strategies. We have had a bit of discussion today about trying to make changes in specific environments, such as work sites or in server training, where we're trying to change the consumption patterns and behaviors of persons in relatively limited environments. This is certainly consistent with the discussions we had in Scarborough. Today we also continue discussions about changes in larger societal environments. Our past efforts in this area have been to have an impact on the direct measures of alcohol consumption. We've done that with alcohol taxes, as well as with changes in the minimum drinking age. These prevention activities and programs have direct impact on societal drinking patterns and documented results.

In the last few years, however, we have seen a new kind of societally focused prevention activity. The focus of this activity is not necessarily directly to change personal drinking patterns, but to change intervening measures or variables. Ron Douglas and some of his colleagues were talking at Scarborough about social marketing. What we've seen in the last 3 years, I think, is the emergence of media advocacy, an extension of social marketing. At Scarborough I think the only paper that addressed using controversy as a planned strategy was Sally Caswell's paper on her New Zealand project.

In the last 3 years controversy has increasingly been developed as a critical element of prevention programs. In the United States citizens have been protesting the new products of the alcoholic beverage industry, St. Ives and Powermaster, as well as new sales outlets, such as gas stations and fast food restaurants. Many of these activities focus on the intervening variables or social norms, and I think we have to improve our outcome measures to be able to make explicit the link between influencing intervening variables and the

subsequent impact on direct drinking measures. I think that's a real challenge for us because advocates are increasingly comfortable with a goal of altering social normative standards as opposed to particular drinking patterns. This area is where we particularly have a lot to learn from tobacco advocates and from tobacco prevention projects—it has been the change in the social normative structures that has led to reductions in tobacco use. Today we can be more comfortable in making what a few years ago would have been viewed as leaps in assumptions about causal links.

I remember that at the second Charleston meeting, a meeting of prevention researchers and advocates, there was a discussion of "Do we have research that should influence policy?" Was there research to guide policy? At that time we focused on development of policy relevant to research. The question a few years later was "Should researchers influence policy development?" By then the relevant research was completed and now there were researchers sitting around asking, "How come they don't pay attention to my work?" We had the data, but no one paid any attention! So a few researchers began to be more active in trying to promote and interpret the implications of this policy research. Today I hear a discussion that is not *do we*, or *should we*, but *how*—how should researchers influence policy development? There have been a number of papers that reflect on that. I just would like to point out that from my point of view that is a major shift, a major difference from Scarborough and also over the last decade. I think it is healthy. Others, of course, say that science has now been tainted. We had some discussion today about ethics; the appropriate role of researchers in formative, process, and outcome evaluations.

During our alcohol tax initiative campaign we were guided in the development of the legislation, in the formative process, by research evidence, and we tried as best we could to keep faith with the literature while we were struggling with the political realities of where we were going to get the money to collect one and a half million signatures and to run a campaign in which we knew the alcohol industry would spend \$30 million against us. Those were very tough issues. Fortunately, we were guided by researchers in this field when we drafted that legislation.

We have a desperate need, I think, for process evaluation. We built into the alcohol tax initiative campaign efforts to document the process. We are learning that there's a great deal to be shared among advocates, and we also know that advocates don't write—they simply don't sit around and write things down. That is the type of research help we need, and maybe we have to call more on the disciplines of sociology, anthropology, and political science.

I wish we had some outcome research on the Alcohol Tax Initiative. After our ballot loss, our politicians suddenly found the courage to increase California alcohol taxes by over \$200 million annually. Jan Howard's point today that we need a ready response unit to be able to go in and take baseline measures

fairly quickly when these seemingly spontaneous activities occur is very important, so that we can in fact have some outcome data about some of these community initiatives that we know will be replicated elsewhere.

Finally, I've been particularly concerned about the development of formal working agreements between advocates and researchers, perhaps even some discussion of the ethical basis for collaboration. We built into our campaign some process evaluation. Yet even after we did that, it was very scary to reveal inside sources to outside observers. I still worry about how they're going to use those data. These are ethical working agreement issues that I think bear discussion. Norm Giesbrecht pointed out there's a tension, and I think we can identify those sources of tension and consider in advance how to address them.

In closing, I should probably warn you and give you some counsel on what will happen over the next couple of days. One, Ron Douglas will tell a very terrible joke. I'm surprised he got through today without one. I have never seen Stig Larsson this quiet. Last time, in Scarborough, there were no other Swedes that I recall, and it may be his countrymen who have kept him in check, but I suspect he will overcome the rigors of travel and revert to form tomorrow. If you want good counsel about what not to do in Tijuana, talk to Louis Gliksmen. He has extensive field experience in Tijuana and you should be guided by his lessons. Before this is over Robin Room will give us an analogy of a 1930s movie that has revealed everything we will talk about in the next 3 days. Sally Caswell will appear to be a demure and quiet person but she's probably the most prescient person among us. It's always a joy for me to talk to Sally and catch a glimpse of what we're going to be doing for the next 3 years. I look forward to the rest of the papers and becoming friends with everyone who is here. Thanks very much.

CHAPTER 3

Community Trials Design Issues

Tradeoffs Between Science and Practice in the Design of a Randomized Community Trial

Alexander C. Wagenaar and Mark Wolfson

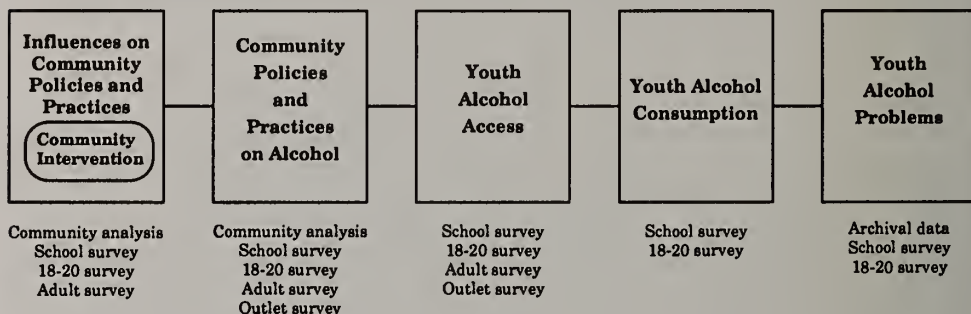
We recently initiated an 18-community randomized trial of community interventions designed to (1) reduce the availability of alcohol to youth under the legal age for purchasing alcohol; (2) reduce alcohol consumption among youth under age 21; and (3) reduce injury morbidity and other health and social problems associated with alcohol use. Evaluation of the intervention will include measurement of (1) both the perceived and actual degree of alcohol accessibility to youth in the study communities; (2) differential access by characteristics of individual purchasers, social situations, social groups, alcohol selling establishments, and communities; and (3) a range of alcohol-related behaviors and outcomes using longitudinal survey methods and time-series analyses of archival records.

Objectives of the intervention program are to (1) change community policies and procedures to reduce accessibility of alcohol to youth; (2) reduce the number and proportion of alcohol outlets selling to underage individuals; (3) reduce youth access to alcohol, whether the source of alcohol is commercial establishments, parents, other adults, or other youths; (4) reduce support or tolerance of underage purchase and consumption of alcohol among youth and adults; (5) reduce prevalence, quantity, and frequency of alcohol consumption among youth ages 15 to 20; and (6) reduce the incidence of alcohol-related health and social problems among youth ages 15 to 20.

This project is distinguished from previous work in that we are developing and testing an intervention to reduce underage alcohol use and problems that uses the community as the *vehicle* for the intervention, not just as a *site* for the intervention. We will test the effects of a theory-based standardized process of community activation, rather than evaluate the effects of any single intervention strategy or activity. Our objective is to change community policies and practices and not simply change the behavior of an aggregate of individuals in a community—the focus of most previous community studies.

The conceptual model informing our research and intervention design is depicted in the figure below. The model consists of five major components: (1) influences on community policies and practices, (2) community policies and

practices on alcohol, (3) youth alcohol access, (4) youth alcohol consumption, and (5) youth alcohol problems, with causal links assumed between each successive component. A strong theoretical basis, as well as some empirical evidence, exists for each of these links. The proposed research will allow us to evaluate systematically each link and the adequacy of the entire model. Planned data collection efforts relevant to each major concept are listed below each box.



Two research designs will be used to determine the effects of the intervention on youth alcohol access, alcohol use, and related problems—a randomized community trial and a time-series design. The randomized community trial will have nine socially and geographically distinct upper Midwest communities randomly assigned to receive the intervention program, with nine others serving as controls. The randomly assigned intervention communities will receive a multidimensional community organization program.

The second major research design to be used is a multiple time-series design, nested within the randomized trial. A time series is an outcome variable measured at many points in time (typically a minimum of 30 time points). When time-series data are available, a time-series design provides many advantages over pre- and posttest designs. It is the strongest design available when random assignment is not possible, and with random assignment provides levels of internal validity even higher than pre- and posttest randomized trials (Campbell and Stanley 1966). Furthermore, time series allow explicit examination of the functional form of the intervention effect, providing additional evidence on the applicability of the theory on which the interventions are based, and illuminating the specific mechanisms of intervention effects. Because of the advantages of time-series designs, we include time-series analyses of those outcome indicators measured through archival records (e.g., injuries, automobile crashes, alcohol sales), where large numbers of observations over an extended baseline and postintervention period are available. In short, we combine randomized trial and time-series designs using data from surveys, observations, and records to maximize information on whether the intervention had an effect, what types of community and individual outcomes the intervention affected, who was affected, and the mechanisms through which the intervention program caused community change.

In the course of designing this project, an interdisciplinary group of investigators discussed and debated numerous issues that represented tradeoffs between theories and models of effective community practice and theories and models of quality scientific research. Tradeoffs or compromises were debated on issues such as research objectivity versus community advocacy, power of the research design versus power of the intervention, use of easy- versus difficult-to-implement interventions, individual versus community consent, community empowerment versus research need for control, and conflict versus cooperative approaches to community action.

Objective Research Versus Community Action

The first issue to be balanced in community intervention trials is that between objective research and community action. The culture of research is value free, objectively seeking the truth, using a clearly defined and shared set of methods for knowing (the scientific method, randomized experiments). But community intervention inevitably implies actions designed to change communities from their current state to another (presumably better) state. Community action thus inevitably rests on values—in our project, values supporting public health. Engaging in research also requires actions, decisions on questions to ask, theories and models to use, data to collect, and analytic techniques to use. As Sievers (1983) puts it, “action(s)...imply in their consequences the espousal of certain values and...the rejection of certain others.” Research therefore also cannot be conducted in a value-free environment. At core the tradeoffs between research and community action reflect tradeoffs between competing values, not tradeoffs between value-free objectivity versus community advocacy efforts.

Power of Research Design Versus Power of Intervention

A second compromise in the design of the community intervention trial is that between the power of the research design and the power of the intervention. A powerful research design requires extensive control by scientists: (1) control over which communities will be selected to participate in the study (preferably a random sample of communities from a defined population of communities); (2) control over which participating communities receive the intervention and which serve as “untreated” comparisons (preferably randomly assigned); (3) detailed control over the exact nature of the intervention, specifying protocols in detail to ensure complete uniformity in treatment across communities; and (4) control over the data collected, including which concepts are measured when and with what methods, and when and how the resulting data are released to the community and the general public.

However, a powerful intervention requires extensive control by local community organizers. For maximum intervention success, the organizers need to control which communities receive the most effort, the timing of intervention efforts, the exact nature of the intervention adapted to local conditions, the

types of data most useful to local constituencies, and the timing and way in which collected data are released to various sectors of the community. Such control by community organizers will permit them to adapt to constantly changing local community conditions in ways that maximize the chances for achieving significant social change. However, giving the local organizers the flexibility needed to do their work violates a number of the requirements for a quality scientific experiment. To the degree to which we permit scientific values and requirements to predominate, we create an intervention trial with a lower probability of achieving the intervention objectives. To the degree to which we permit the values of local community organizing to predominate, we increase the chances of achieving social change but decrease the chance of scientifically verifying those effects.

Easy Versus Difficult Interventions

A third tension or tradeoff in the design of the trial is the use of easy- versus difficult-to-implement interventions. In community practice, an easier intervention is usually preferred, for two reasons. First, all other things being equal, practitioners will often choose sites for interventions that in some sense display readiness to make significant changes. Second, in designing an intervention, those that are manageable and stand a good chance of successful implementation are preferred. Of course, there are a number of exceptions to this tendency. Still, ease of implementation and favorable odds of success are very often important considerations in designing interventions and choosing intervention sites.

The considerations for designing interventions to be used in an experimental design are somewhat different. On the one hand, interventions that can be effectively implemented with relative ease and high odds of success are preferred. However, in an important sense, interventions that are so easy to adopt that they are subject to ready diffusion or independent adoption in control communities present a threat to the validity of the design. Thus, in designing the intervention to be used in our community trial, we have tried to strike a balance—the intervention should be easy enough to implement that it stands a fair chance of succeeding in at least a majority of the treatment communities, but difficult enough that diffusion and independent adoption are unlikely.

We believe our intervention strategy will achieve this balance for several reasons. First, most of the local policies and practices regarding youth access to alcohol in which we are interested are early in the diffusion process. Based on the available evidence, the chance of a control community significantly changing their community policies and institutional practices on underage access to alcohol appears slim. Major changes in access over the past 20 years, such as changes in the legal alcohol purchase age, were the result of intensive multi-year campaigns (Wagenaar 1983), often involving significant grassroots pressure and Federal financial incentives (Wolfson 1989). More relevant to the community level of analysis in the current project is the experience in California communities with

regulations on concurrent sales of alcohol and gasoline. Implementation of such regulations followed a classic diffusion curve, with very few in the early years and increasing numbers of communities in the latter years (Wittman and Hilton 1987, personal communication, 1991). Recent experience with measures to restrict youth access to tobacco in Minnesota also demonstrates a low natural adoption rate (Forster et al. 1990).

Finally, it is possible that one or more of our nine control communities might implement a notable policy or programmatic change relevant to youth alcohol access. However, the effect of such a change on the power of our design is likely to be small, because it involves a single discrete component of our overall intervention. Treatment communities will be engaged in a coordinated set of policy, procedure, and practice changes designed to reduce youth access to alcohol. It is extremely unlikely that a control community will spontaneously initiate a similar multicomponent effort during the same period we are implementing our intervention in the treatment communities. Moreover, we expect that the process of community mobilization that influences the adoption of policies will also enhance the effectiveness of those policies. Specifically, the community and political support as well as publicity for policies generated by a high level of community involvement will contribute to their effectiveness. Even if selected control communities adopt some elements of the intervention in the form of specific policy or practice changes, they will not experience the process of community mobilization that we will be implementing in the treatment communities.

Individual Versus Community Consent

A fourth issue in designing a community trial involves the nature of consent procedures. Typically, scientific studies require that each individual participant consent to provide information to or submit to experimental treatments conducted by the researchers. In our community intervention trial, we will use standard active and passive consent procedures for the various surveys we will conduct. However, in the randomized community trial, the *community* is the unit of intervention and analysis. The intervention will both take place in each of nine treatment communities and will use (in large measure) indigenous community resources. This methodology raises the question of what rights or responsibilities, if any, the community as a whole has in consenting or not consenting to the experimental treatment. A number of important ethical and practical issues are embedded in this question.

What procedures could be used to obtain community consent to a community intervention? Using standard individual consent procedures as a frame of reference, we might think of distinguishing passive and active community consent. Active community consent implies obtaining the consent of the community as a whole or of community representatives for the intervention. Immediately, a host of questions are raised. Does one hold a plebescite on whether or not an intervention is acceptable to a community? Clearly, this

option is not realistic. But what community representatives should one turn to for consent? Local elected officials are one option. In fact, we view the involvement and support of key officials as an important (although not essential) element that will contribute to the effectiveness and viability of the intervention. However, local officials often represent the status quo, may be resistant to fundamental change, and may exclude or inadequately represent segments of the population that our intervention will seek to empower. Alternatively, one might try to obtain the consent of representatives of a variety of leaders of organizations and segments of the population. However, this too involves many of the same practical and conceptual difficulties mentioned above.

In practice, passive consent might be a more realistic and practical approach to the issue of community consent. Passive consent may be thought of in several ways. First, it is possible (although highly unlikely) that once community representatives have learned in some detail about a planned community intervention, they will unite in opposition to it. A more likely scenario is that a subset of key community leaders and organizations will refuse to cooperate with the intervention. For example, key government, school, or business leaders may refuse to sit on a community task force. Does this constitute nonconsent? It certainly means that consent is only partial. But if one limits oneself to completely nonobjectionable interventions, it is likely they will have little or no impact. It seems clear that community consent, while an intuitively appealing concept in the abstract, presents a host of conceptual and practical issues in its implementation.

Empowerment Versus Control

A fifth tradeoff in designing community interventions involves community empowerment versus control of the experimental treatment. The debate falls under the larger issues surrounding the control of a community project, which were alluded to earlier. An experimental design involving community organization intervention techniques faces a paradox. Community organization is most effective when it is not rigidly controlled from above by a unit of government, research institution, or other entity. Rather, it is most successful when a partnership approach is used in which the sponsoring unit provides guidance and assistance, but considerable autonomy is retained by the community. Local autonomy, however, raises the possibility of treatment heterogeneity in the context of an experimental design. How can the requirements of successful community organization and experimental validity be satisfied?

We believe that, in practice, the paradox suggested by this important question is more apparent than real. Our previous experience with community organization approaches in the areas of cardiovascular health and tobacco use suggests that community representatives actively seek guidance on potentially effective intervention activities, and that the intervention staff can have considerable influence at this point. In our experience, not one community has deviated in a fundamental way from the main thrust or orientation of the intervention effort.

Second, our conceptualization of the intervention is *not* an exact set of strategies and tactics for changing enforcement practices, regulations, and institutional policies related to youth access. Rather, the intervention protocol consists of a standardized *process* of community mobilization, involving community analysis, community education, and task force formation, and the development and implementation of a plan of community action. Each of these components includes elements that will help shape a community's approach to the problem of youth access to alcohol.

Community analysis is a process by which potential change agents are identified within communities. This process will enable us to identify people in local communities whose orientation to alcohol issues is (or, through our education efforts, could become) consonant with our own. Of course, there will inevitably be some diversity of opinion and orientation on community task forces.

The process of community education also provides a number of opportunities for influencing a community's response. In our experience, the ways in which issues are framed carry considerable weight in community education efforts. We are confident that the data we present on the nature of the youth access problem in a community, along with data on the relative effectiveness of approaches that have been tried elsewhere, will be effective in promoting a community-level orientation and approach that is largely consistent with our model.

A community organizer (as well as other intervention staff) will assist communities in developing and implementing a plan of action. Organizers will be specifically identified and hired for this project. We will not simply rely on individuals currently working in the communities on alcohol issues. Moreover, organizers will all receive the same intensive training on both alcohol issues and community organizing. Both the selection and training of organizers will help ensure that the advice and assistance they provide to communities are consistent with our theoretical framework.

Finally, if communities wish to implement specific components that we do not see as essential, we will not prevent them from doing so. Instead, we would try to shape those activities to support our intervention model. For example, we believe mass media information campaigns are of limited utility in changing drinking behavior. If members of a community wished to implement such a campaign, we would encourage them to design it so that it supports our focus on youth alcohol access and the role of institutional policies and practices in encouraging drinking by youth. Such a media campaign, then, might disseminate information on the prevalence of service to minors in the community, building support for other community actions, rather than only attempting to change behavior directly. In summary, a standard approach to mobilization will be used in each of the treatment communities. Although the mix of

strategies adopted by community task forces will naturally vary from community to community, a number of features of the intervention approach will ensure a high degree of consistency with our theoretical framework, making significant heterogeneity of treatments unlikely to occur.

Conflict Versus Cooperation

A sixth compromise in the design of a community intervention trial is the relative emphasis on conflict versus cooperation as a means to achieve community change. Sectors and organizations within a community are highly interdependent, and alcohol problems are frequently ill defined with multiple perspectives on the nature of the problems and appropriate solutions. As a result, a cooperative process provides numerous benefits: better solutions emerge from the interaction of various perspectives; diverse constituencies believe that their interests are seriously considered; various constituencies are more likely to accept and work to ensure success of a jointly developed solution; various constituencies retain ownership of the issue and its solution; and community capacity for resolution of other future problems is enhanced (Gray 1989). However, a cooperative approach also has limits. The various constituencies may not be willing to engage seriously in public discussion of alternatives. The constituencies are not likely to be of equal power and, if there is a substantial power differential, those with power are likely to use the cooperative process to advance their own ends. Early participation by powerful segments of the community with strong vested interests in the issue may result in a solution set that is narrowly framed to include only actions acceptable to that interest. In such a case, some community constituencies might be initially excluded from participation until other constituencies work out a broad solution set and form a coalition with sufficient power to balance the disproportionate power of any particular constituency. Gaining power to counter a powerful constituency may require effective uses of conflict. Conflict and confrontation can be used to force a constituency to address community problems with alcohol. After experiencing the power of constituencies concerned about alcohol problems, those with vested interests in the status quo are then forced to participate and compromise in community problemsolving efforts. However, individuals and groups using conflict to spur change typically should not be the same individuals or groups who then work to identify cooperative solutions, because they will not be trusted by those who were their targets. In short, conflict approaches need to be balanced with cooperative approaches to community change. Conflict approaches can be used to achieve a more equal distribution of power among various constituencies, who then may collaborate to identify and implement effective solutions.

Conclusion

Designing and implementing effective community intervention projects as scientific experiments require a careful balance between the needs of science

and the needs of community organization practice. Open discussion and debate between those most oriented toward scientific norms and values and those most oriented toward the norms and values of community practice are essential in project design and planning. There is no single optimal balance between these competing concerns. However, open debate and consideration of these tradeoffs and the potential consequences of a decision to tilt one way or the other on each specific issue maximize the odds that the requirements of good science and the requirements for good community practice are both met for an effective intervention effort that is scientifically verified and ready for broader dissemination.

Acknowledgments

We wish to acknowledge the contributions of the investigators involved in the "Communities Mobilizing for Change on Alcohol" project. Thanks to Neil Bracht, Harry Boyte, John Finnegan, Jean Forster, Mary Hourigan, Rhonda Jones, Knut-Inge Klepp, Peg Michels, David Murray, and Cheryl Perry for their participation. Preparation of this paper was funded in part by grant R01 AA09142 (A. Wagenaar, principal investigator), jointly funded by the National Institute on Alcohol Abuse and Alcoholism and the Office for Substance Abuse Prevention.

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Symposium Plenary Discussion

Opening the discussion period, Norman Giesbrecht said he believed that Alexander Wagenaar had given the issue of the research agenda versus the community action agenda a more negative twist than necessary. "I think the interaction between researchers and the activists can produce a more enhanced project, even in terms of the mobilization of the intervention," he said. Wagenaar responded that he had dichotomized the issue in order to generate discussion. Clearly, he said, researchers are informed by their involvement in community projects, but he thinks there are differing values and perspectives in research and community practice that can emerge as conflicts.

Harold Holder raised the question of "reactive compensation" in experiments that involve a matched control community. He told of a smoking trial in North Carolina where the community chosen as the control decided to do its own program, passing antismoking regulations more stringent than those imposed in the experimental community. He noted another case where leaders in a California community expressed resentment because their community was chosen for the second time to be a control community in a health research project. Prevention planners need to be wary of creating conditions where they actually confound their own design. Wagenaar commented that this situation has been discussed in the literature, and is usually only a problem when there are two communities involved and one is selected for an experiment and the other is identified as a control. He believes it is less of a problem when, as is the case in his project, 18 communities in a single region are involved and none is identified as being matched with another community.

Commenting on the tensions involved when the same people serve as evaluators and as program developers, Kathy Stewart noted that in the Fighting Back initiative her group is doing only the evaluation. "In some ways this makes our role simpler, but it can also be somewhat frustrating. We're the scientists standing back with clipboards taking notes on what's happening. At times we feel like we're seeing people engaged in an earnest discussion while a freight train is bearing down on them, and we're not in a position to make any comments."

In response to a comment by Diane McKenzie about the problem of making assumptions about the effect of an intervention when no one really knows whether it will work, Wagenaar said his group is working at the outset in a pilot intervention community. Data collected in the pilot effort were provided to a community group, which then collected some additional information on its own and sought advice from the researchers on how the community might proceed to remedy the problem of youth access to alcohol. The community group succeeded in having a bill introduced in the State legislature to control the sale and consumption of beer from kegs statewide. "The bill has not been passed, but this illustrates the notion that you don't know what a half-hour

presentation to a subcommittee will lead to," Wagenaar said. Referring to Eckart Köhlhorn's comment on the difficulty of changing behavior, he said that some interventions aimed at creating or changing a policy can turn out to be surprisingly easy. In another case, a brief activity led to the adoption of an ordinance making significant changes in the way tobacco is sold by retailers.

Paul Duignan, commenting on the tradeoff between science and community practice, pointed out that astronomers study events and conditions over which they have no control. "I think we should see ourselves as doing good science in a field that has some constraints," he said, adding that he believes the bigger conflict is over the question of whether priority in resource allotment should go to research or to community action.

Robin Room then commented on the issue of easy versus difficult interventions. He said the kind of design Wagenaar described is conceivable only when dealing with a powerless segment of the population, such as children. He contrasted the Minnesota project in which 18 cities are persuaded to cooperate in an intervention aimed at youth with Shireen Mathrani's example from Oxford of the resistance to an attack on a city hall pub popular with middle-aged males. He also commented that Diane Walsh's study approached 57 workplaces before it found one that agreed to be studied. Would Wagenaar's project be much more difficult if he were attacking principles defended by more powerful interests in a community? Wagenaar responded that targeting the adult population would indeed be more difficult than targeting youth, and that the project design might have to be modified if applied to other populations.

Stig Larsson raised the question of how Wagenaar's project would make use of knowledge that is not derived from research or scientific method but would have validity. Wagenaar said formal research is the main focus in his design, but there is another layer to the project. The organizers will collect data daily from their community work. This knowledge and experience will inform both their actions and others through regular information sharing among the communities.

Design, Implementation, and Evaluation of a Community Action Program for Prevention of Alcohol-Related Problems in Stockholm City: Initial Experiences

Anders Romelsjö, Anders Andren, and Stefan Borg

Introduction

This paper is a rather straightforward report of a community intervention project aimed at reducing alcohol consumption and alcohol-related problems in Kungsholmen, a metropolitan community in the Swedish capital of Stockholm.

Alcohol problems can be seen in a *systems perspective* (Holder and Wallack 1986), which implies using activities from a broad societal and environmental perspective to prevent alcohol problems in a community, taking various sub-systems into consideration. The *total consumption model* implies that a reduction in mean alcohol consumption is an important objective also in a community intervention project.

Our project has a steady footing in the public health care sector in Stockholm County, which of course has affected expectations and activities. The project is *focused on primary prevention, but includes secondary prevention* and also aims at improved cooperation among authorities who have contacts with people with more chronic alcohol problems. This aspect is valuable for the general credibility of the project.

Planning and Implementation

Initiation and Economic Support

This research project is not freestanding. The project idea came from Dr. Stefan Borg who, as chief of the Department of Treatment of Addictions, wanted to increase prevention work, and Dr. Anders Romelsjö, who has a public health and research interest and saw this engagement as part of his work as a medical officer in the public health sector. The initial funding was received in February 1990 from the Health Promotion Committee of Stockholm County, which is composed of politicians from the county and the municipalities and has the main task of supporting prevention. The project has been re-funded by this committee, and has also received economic support from the Board of Social Welfare in Stockholm City, the National Board of Health and Welfare, the Research Committee of the Center for Research on the Elderly in Stockholm, and the Research Committee of the Alcohol Retail Monopoly.

Study Area

The community of Kungsholmen in the central part of Stockholm was selected mainly because of local interest in primary care at the Social Welfare Agency, and especially at the Department for Treatment of Alcoholism and Drug Abuse. Second, the rates of mortality and inpatient care for alcohol-related diseases were above the average for Stockholm County. Kungsholmen as a community is defined rather loosely as a geographical area where people live and can easily come in contact with each other. Around 45,000 inhabitants live in Kungsholmen, which has a considerable influx of people during the daytime because some large enterprises are situated there. The proportion of old age pensioners is high (approximately 27 percent), while the proportion of children and youth is lower than the average for the county. However, the proportion of inhabitants in the working ages (20 to 64 years) is the same as in Stockholm as a whole (62 percent). The socioeconomic structure is rather heterogeneous. The proportion of the population with a college or university education is higher than the average for the county in some areas. In other areas this proportion is lower and the mean income is lower. The unemployment rate is low (around 2 percent), same as for the Stockholm area as a whole. Five percent of the population has foreign citizenship while the average for Stockholm County is 9 percent. One can wonder if there is any sense of community among the inhabitants in this metropolitan district. In a questionnaire survey (see below) 35 percent of the responders felt a strong affinity with the area, while 40 percent admitted a rather strong affinity. Fifteen percent said they had no sense of area kinship, while 11 percent felt uncertain. We found quite a few influential local voluntary organizations, however, and have judged that they will have a limited role in our study.

Marked Local Initial Support

The first year, 1990, was used for theoretical and practical planning of the project:

- A project plan was worked out with goals for various areas and evaluation. The overall objective was a reduction of alcohol consumption and alcohol-related problems in the community.
- Four project workers were hired.
- Data collection was started as part of a community diagnosis.
- Various organizations or local authorities were contacted and generally showed great interest. It seemed necessary to start the work by contacting authorities and organizations to get an idea about their interest. Although we started this work "from above," we aimed to replace this approach with "bottom-up" activities. Our idea was that it would be easier to work and engage people at the grassroots level with support from some important societal bodies.

Community intervention work depends on factors in the local community but also on the role of the change agents and the interplay and cooperation between the change agents and the population. Influenced by Bracht (1991), we think that, despite local variations, one can mostly identify various phases at least in the planning stage: community analysis, initiation, implementation, integration of the programs into the ordinary activities in the community, and evaluation of processes and results.

Community and Scientific Reference Groups

Since autumn 1990 we had had five generally successful meetings with the local group and two with the scientific reference group. The local reference group so far is composed of representatives from the high school, the social welfare agency, the police, primary health care, the Department for Treatment of Alcoholics and Drug Users, and the health care sector. We are members of the working party for collaboration between local bodies working with young people in Kungsholmen, which also has been a second local supportive reference group. We keep in touch with members of those groups, collaborators, and other bodies through a separate four-page newsletter.

Some Concrete Project Activities

The project activities are summarized in table 1. They are, of course, influenced by our position as part of the health care sector and the main funders, the Health Promotion Committee in the county and the Board of Social Welfare in Stockholm City.

School Education Program

At the high school we were able to institute a program to increase education predominantly about alcohol, but also about narcotics and tobacco, among pupils ages 14 to 16. The education program aims to encourage pupils not to start using alcohol, to avoid drinking to intoxication, to increase the pupils' knowledge about alcohol, and to stress their own responsibility in a choice situation. A special textbook was worked out for this program. Meetings also have been held for parents, in collaboration with the school and the youth group at the social welfare agency. Some education was directed toward teachers.

As part of the evaluation, an anonymous questionnaire survey of alcohol habits was conducted in spring 1991; this school was separately included in repeated national surveys of the use of alcohol, narcotics, and tobacco in a sample of school classes for pupils ages 13 to 16. According to this survey a surprisingly high percentage of the pupils had drunk homemade liquor. The reporting of this fact at meetings with parents and teachers was met with great interest, worry, and hot debate. The program at school is also being evaluated with a test-retest study of alcohol habits and attitudes among the pupils.

Table 1. Preventive activities by type of prevention, target group, and kind of organization

	<i>Primary prevention</i>	<i>Secondary prevention</i>
Adult population		
Poster campaign	+	+
Alcohol carrousel	+	+
Public meetings	+	
Local press	+	
Anti-bootlegging campaign	+	
Public drunkenness/drinking and driving		+
Young people		
School education	+	
Anti-bootlegging campaign	+	
Education of teachers	+	
Meetings with parents	+	
Exhibition of pupils' drawings	+	
Youth place	+	
Youth seminars	+	
Local alcohol policy program	+	+
Children		
Education of personnel at day care centers and nurseries	+	+
Movie on parent and child relations	+	
Elderly		
Social support and alcohol consumption	+	
Pregnant women		
Education of midwives	+	+
Health care services		
<i>Primary care</i>		
Education of physicians	+	+
Secondary prevention policy		+
District nurse education	+	
<i>Hospital care</i>		
Education of physicians	+	
Education of social workers		+
Policy program		+
<i>Occupational health services</i>		
Education of physicians	+	+
Treatment of alcoholics, "school for relatives"		+

A small campaign against bootlegging directed toward young people was conducted in connection with the school vacation in June 1991. The campaign was a collaboration with the working party for local groups that work with young people. All restaurants in the area were asked to put up a poster with the message "We love young people, but we cannot serve you alcohol when you are underage." The local alcohol retail stores agreed to put up a similar poster and were asked to increase their checking of ages. The main stores were asked not to sell beer during the period of school vacation. An advertisement in a local newspaper carried a similar message.

Activities Directed to Parents of Small Children

We have arranged 2 days of education for employees working at the day nurseries and at the leisure homes with children ages 1 to 10. The aim is to increase knowledge and awareness about the connection between the drinking habits of parents and the well-being of children and to increase the knowledge of how to find and help parents who consume large amounts of alcohol. Almost 100 employees from our area attended this training. Together with other interested parties, they started planning a short educational movie about the connection between an adult's alcohol habits and the well-being of children. We think that this kind of movie could be used to reach almost all parents at the free health examination for children between the ages 0 and 7. The crucial task is how to convey in an acceptable way the message that small children learn from the attitudes and the behavior of parents where alcohol is concerned.

Other Activities With the Social Welfare Agency

One important goal is for the local social welfare board to adopt an alcohol policy act in 1992. One group is working to find support for a new meeting place for young people. The goal for another group is to improve the work by the social welfare agency, in collaboration with the health care sector, regarding subjects cited by the police for drunkenness or drinking and driving, in order to find and help people in the early stage of alcohol abuse. We have recently been funded to form a task force for a project to reach elderly persons who consume large amounts of alcohol.

Activities in the Health Care Sector

A major goal is to increase awareness among physicians and other personnel of possible alcohol-related problems in their patients and to increase secondary prevention activity. Education programs have taken place, and the interest has generally increased. In autumn 1991 a policy paper calling for collaboration on identification and treatment of consumers of large amounts of alcohol was worked out among representatives from the main departments (internal medicine, surgery, orthopedics, urology, psychiatry) at the St. Göran's University Hospital, the only hospital in Kungsholmen. A similar policy paper has been

accepted by general practitioners. Social workers at the hospital have been especially supportive. The project is represented in another program at the Department for Treatment of Alcoholism and Drug Abusers, which aims at giving support to relatives of persons with alcohol problems. We found considerable interest among the midwives at the free maternal health care to improve their interviews with pregnant women about alcohol habits and to give advice about alcohol consumption.

A Primary Prevention Campaign in the Community

A more comprehensive campaign directed toward those persons ages 20 to 45 was undertaken for 4 weeks during autumn 1991. The general aim was to attract interest in alcohol issues in the community and to increase awareness about one's own consumption without being moralizing or condemning. Three main activities were conducted: a poster campaign in the community and at subways throughout the county, the distribution throughout the community of an "alcohol carousel" made of colored paper, and three public cultural events during evenings. The slogan of the poster campaign was "A bottle of liquor a week." "Ordinary" men and women in seemingly good social conditions were portrayed (without face), and it was shown that their "ordinary" drinking habits amounted to approximately 75 centiliters of spirits or more. The aim was to make people aware of their drinking habits and to reconsider those habits. With the "alcohol carousel" a person can easily calculate his or her alcohol consumption in centiliters of spirits, and also the cost per year, calories per year, calories expressed as the number of Danish pastries consumed per year, and so on. Approximately 100 subjects, who seemed quite interested, came to each of the evening meetings. The campaign was also presented in the monthly community newspaper, which is said to be read by "everyone."

Evaluation

Our project raised the following questions:

Will knowledge about the project increase in the community?

Will attitudes toward a restrictive alcohol policy become more positive?

Will self-reported alcohol consumption decrease more (or increase less) in the intervention area than on average in Stockholm County and more than in the control area?

How will different social strata be affected?

Will there be any reduction of alcohol-related problems?

Will the guidelines for secondary prevention be implemented? Will people at the grassroots level be engaged?

Activities at the Community Level

The following lists the tasks of the program thus far accomplished and others that are planned:

- A questionnaire study of drinking habits and attitudes within a general health survey was carried out in spring 1991 in the intervention area and in a similar area in another Swedish city. The survey included random samples of 2,000 adults in each area. A similar questionnaire survey will be conducted after the project. We find three results from this survey to be especially interesting:

- There is a strong opinion for a more liberal alcohol policy. Fifty-one percent of the men were for the sale of strong beer in ordinary grocery shops, and 43 percent for sales of wine and spirits in such shops; the corresponding figures among women were 40 percent and 32 percent. Since the end of the last century alcoholic beverages have been sold only at State-owned retail stores and restaurants (at high prices) in Sweden.

- There was a positive association between the consumption level of alcohol and a liberal attitude.

- In a methodological study within the survey, we found a very high coverage of questioning about the consumption of each alcoholic beverage during Monday through Thursday, Friday, Saturday, and Sunday, compared with the usual volume/frequency questions.

- A survey about alcohol habits at the high school and a test-retest study has been conducted (see above).

- One survey on attitudes about alcohol of a random sample of 1,200 subjects ages 20 to 45 was conducted before the autumn campaign. A second retest survey was directed to approximately 700 respondents; questions about project activities also were asked. A third survey of attitudes in a new random sample is also being performed.

- Data on inpatient care, drinking and driving, mortality, and subjects taken into custody for public drunkenness for this area and other areas in Stockholm County will be analyzed.

- A study by the Alcohol Retail Monopoly, which supports our project, found that roughly 50 percent of the customers at the three alcohol stores in Kungsholmen did not live in the area. Thus, sales data will be of limited use in our evaluation. For similar reasons it seems uncertain if data on sales at restaurants will be of any use.

- Our plans to conduct repeated measurements of alcohol involvement among subjects ages 20 to 74 treated in the ER at the hospital were not successful.

We had planned to analyze the data with interrupted time-series analysis and to connect this analysis to program activities, and also to use the data for education at the hospital. The measures were to be based on analyses of the blood test carbohydrate-deficient transferrin (CDT) (Stibler and Borg 1986), which is a new indicator of high alcohol consumption with a high sensitivity (approximately 80 percent to 90 percent) and a high specificity (approximately 99 percent). This project failed in spite of support from the personnel who were to take the blood specimens. They encountered difficulties in getting consent for blood tests from the patients, even though the study was anonymous. Blood specimens were taken only from a minority of patients.

An Assessment of the Current Project Status

The project is probably rather widely known in the community, has been met with positive interest, and has initiated or contributed to increased prevention activities. However, we have so far reached people in the general community only to a limited extent. One exception is that people picked up approximately 10,000 copies of the "alcohol carrousel" at shops, banks, health care centers, and alcohol retail shops during the campaign month. As we have secured funding only during 1992, it is important to build better local support and to try to transfer activities to groups or subjects in the community.

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A Community-Based Alcohol and Injury Prevention Project: Reflections From Three U.S. Communities

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Introduction

The Prevention Research Center (PRC) is implementing a 5-year community prevention trial to reduce alcohol-involved unintentional injuries and fatalities—resulting from traffic collisions, falls, drownings, and burns—through the application of environmental strategies (Holder and Saltz 1988). Five interacting and supporting components provide the framework for the set of comprehensive community-based interventions developed for this project. These five components are the following:

- *Community knowledge, values, and mobilization*—Concerns developing community organization and supporting goals and strategies of the project, as well as increasing public awareness and concern about alcohol-involved trauma.
- *Responsible beverage service*—Includes policy changes and training of servers and managers and owners of on-premise alcohol outlets to reduce the risk of intoxicated patrons and/or drinking and driving.
- *Reduction of underage drinking*—Involves community education about the extent of underage drinking, training for off-premise alcohol retailers to reduce access to alcohol by underage patrons, and parent organization and educational activities.
- *Risk of drinking and driving*—Seeks to increase local driving while intoxicated enforcement efficiency and to increase the perceived as well as actual risk of detecting drivers who are under the influence of alcohol.
- *Access to alcohol*—Includes the use of local zoning powers and other municipal controls of alcohol outlet density to reduce the availability of alcohol.

The research design is quasi-experimental with three pairs of experimental and comparison communities; the experimental sites are Oceanside, California; Salinas, California; and Florence, South Carolina. Each site was selected because there was an existing coalition that represented major sectors of the community; the coalition had a genuine interest in the prevention goals and strategies proposed; the community did not have existing trauma prevention programs, and the population was ethnically diverse without being especially unique in comparison to other U.S. sites. Communities with population sizes between 100,000 and 150,000 were selected so as to be small enough for ease of

implementation and large enough to provide an adequate basis for statistical analysis.

In each of these communities, we are working with and through a designated lead agency—non-profit organizations founded by the city council in Oceanside, the county health department in Salinas, and the county authority in Florence. This variability among lead agencies will provide the opportunity to evaluate the potential differences that sponsorship of prevention projects may play in communities (Hennessey 1991; Ratcliffe and Wallack 1985).

This Community Trials Project differs from previous community-based alcohol prevention projects by including all the following components: (1) development of a careful baseline planning and preintervention period; (2) well-defined community-level alcohol-involved problems (i.e., unintentional trauma) as targets; (3) a long-term implementation and monitoring period; (4) a follow-up or final scientific evaluation of changes in target problems; and (5) (we hope) an empirically documented successful impact on the target problem that can be attributed to the intervention (Holder and Saltz 1988).

This project is unique in its application of research-proven strategies within a systems perspective, focusing on the individual within a community context (Hennessey 1991; Ratcliffe and Wallack 1985). As such, the community, as a body, must play a strategic and essential role as a partner in identifying how to apply the research design and implementation requirements for maximum impact within its own context.

The inherent tension that exists between researchers and communities within the framework of community action-oriented research (Giesbrecht et al. 1991) is being discussed throughout this conference. The Community Trials Project has also been wrestling with the balance between maintaining research integrity and developing an intervention program that is responsive to and reflective of each community's needs. Project roles and administrative structures are being developed with this balance in mind.

Project researcher roles are to select intervention and control communities, ensure that selected strategies are scientifically based and implemented according to the conceptual model, develop and implement data collection protocols, and ensure quality control of data collection and its data analysis. The community will be an equal partner in its roles of assessing the appropriate sequencing and timing of interventions and identifying specific strategies to be used in that community (e.g., in one community Responsible Beverage Server projects may be pursued through the local responsible hospitality institute rather than through individual managers or through the local chamber of commerce).

PRC has instituted several structural forms to enhance community involvement:

- An identified project priority to select site coordinators who are well known in their communities (including lead agency and/or coalition involvement in the interview and selection process).
- Coalitions formed or association made with appropriate existing coalitions, which will serve to provide continual input into project planning, as well as provide liaison back into the community.
- Feedback to and from the communities will be coordinated formally through the community mobilization team whose team leader is a member of the project's research coordinating committee. The research coordinating committee's role is to ensure overall coordination of efforts across project sites, as well as scientific integrity of the interventions and evaluation.
- Planning meetings involving community representatives were held within 2 months of project inception.
- Formative evaluation is conceived as an integral part of all planned project components.

Our focus here is to present the perspectives of the key leaders in our three experimental communities on the interface between community and research agendas and priorities. It is based on a series of interviews conducted with them, as well as comments from discussions with coalition members.

Coalition Role

A different project/coalition model has evolved at each of our three sites. In Oceanside our project efforts will be coordinated through the task forces of a coalition organized through an Office for Substance Abuse Prevention (OSAP) grant; in Salinas the coalition overseeing our project activities is being formed as a regional subcommittee of the county's Alcohol and Drug Master Plan; and in Florence we are currently considering whether to work through their new OSAP coalition and its 10 task forces, or whether to establish an 11th task force to address our priorities. Again, these different models will provide a research opportunity to evaluate the different influences that project organizational structure may have on process and impact.

In each of these communities, however, coalition members have defined their role similarly. They see themselves as formally representing the community and providing a forum through which the project can achieve legitimization and serve the larger community. An important role they have identified is helping to work out the inevitable array of potential conflicts that arise in action-oriented research projects. They will be active spokespersons for the project and will assist directly in its implementation. They will also coordinate project efforts with other current and future activities to avoid duplication of efforts.

Structures to Provide for Real Versus Token Community Input

One of the greatest challenges facing community research action projects is how to institute more than token-level community participation; this feature is essential to ensure the community's satisfaction with its level of involvement and, therefore, real project effectiveness and change.

One of our communities previously had been the site for another health research intervention project, and during early conversations with PRC staff expressed lingering feelings of "having been done to." At the initial coalition meeting following project funding, we sought to assuage similar concerns by opening the conversation up to address directly their concerns at the beginning, and by listening to them about how they would like the project to be conducted and organized. Negotiation and agreement about respective roles of project staff (both central and locally hired), lead agency staff, coalition/community members, and location of site staff have been helpful in establishing a cooperative relationship.

Frequent updates regarding project progress have been requested by all the agencies and coalitions. The project is incorporating built-in time for community involvement within the central planning process for each component; this phase will be accomplished through interviews, focus groups, and meetings during the formative evaluation stage to match specific interventions to community needs and styles.

Working through already established structures and processes was identified through this interview process as a key way to ensure community involvement. From the community's perspective, it is also an expression of the researchers' respect for the community.

Benefits and Advantages to the Community of Research-Oriented Projects

Although communities are quite aware of the potential negative effects of research-driven projects, they are also aware of and appreciate the variety of benefits that are derived from this collaboration. Cited in the examples given by our agency leaders is the opportunity to learn from project research staff of new ideas and innovations in the field, which serve generally to stimulate and broaden both agency and community perspectives of potential strategies for addressing other problems. For example, training for local staff in alcohol trauma theory, coalition-building strategies, and conceptual frameworks of the selected interventions will also be available to coalition members.

Affiliation with a research project lends credibility to other substance abuse endeavors in the community and to the agency in general. A desired long-term result from the community perspective is improved skills in effective problem

documentation, planning, and evaluation, thus enhancing its ability to identify and obtain financial support for additional projects.

Additionally, and possibly more important, project structures will provide access to the experiences of other communities, leading to cross-fertilization of ideas, and mutual learning and teaching between the communities.

The ability to document changes in community beliefs, attitudes, and behaviors enables a community to reflect on its own growth and provides motivation for pursuing the resolution of other identified community issues.

Disadvantages and Deterrents of Research-Driven Projects

Although communities are aware of the advantages of participating in research-oriented projects, they also have the clearest vision of the potential costs. Researchers' agendas may not include long-term benefits to the community and may even be insensitive to the issues a community raises.

Earlier research activities that have lacked responsiveness to the community's perspective have left in their wake a negative attitude and skepticism regarding participation in future endeavors; these negative feelings may inhibit a community from participating in future beneficial collaborations. Unless a research project is also committed to responding to community concerns and to providing avenues for them to meet their own agenda, the community is apt to feel "used" as a human laboratory. This concern has been raised by several communities. Although our project objectives do not include addressing the issue of intentional injury related to alcohol, one of our communities has identified this issue as a high priority; we will be working with them to develop data collection procedures to assist in documenting the extent of the problem locally.

All our communities have given us strong feedback that the schools feel "curriculumed out"; attempts to test out new classroom-based approaches would be met with strong resistance. Therefore, since our underage drinking component includes a variety of options from which to choose, we will probably focus our intervention efforts on nonschool-based strategies.

Contributions to the Project Only the Community Can Make

As researchers, it is essential that we realize the contributions to our efforts that only the community can offer. For example, community ownership is required for the institutionalization of project efforts so that interventions do not fold when the researchers pack up and leave. Additionally, community commitment to the project adds a concern for quality control.

Community involvement provides researchers with a reality check for the application of conceptual models and their adaptation, as necessary. Data

collection in these research sites provides additional data for future research efforts and development of new ideas to research.

Community representation provides the support system to work out the inevitable conflicts that will arise during action-oriented research. Established personal and professional relationships within the community provide liaisons that outside researchers do not have.

Political Realities That Must Be Addressed

Successful attempts to prevent alcohol-related trauma from a systems perspective require that the political realities of the community be seriously addressed when developing relationships with community people and agencies, as well as when developing the intervention plan. For example, the Salinas City Council has submitted a lawsuit against the county regarding the proposed redistricting plan that will potentially reduce representation of the Hispanic community. In early meetings with coalition members in Salinas, they articulated concern about our liaison through the county health department and our true commitment to the community of Salinas. We will need to be aware of this issue, especially in our early planning phases. This is just one example of the myriad possibilities where turf issues could negatively impact our project.

In Oceanside political divisions have been created between the "old" versus "new" guard. These divisions grew out of growth and development issues, but eventually became more focused on personality and budgetary differences. Even alcohol and other drug prevention issues, for which there has always been unanimous support, have become politicized more recently.

An issue in each community will be the development of strategies that accommodate competing interests. Educational and environmental advocates will be interested in pursuing access and safety issues, while the business community, which is concerned about drinking drivers, also has a commitment to the financial health of the local economy.

The environmental approach to substance abuse prevention is a relatively new idea in many communities that are still focusing on individual interventions. Discussions with policymakers on the efficacy of addressing these issues from a systems perspective will be an initial step in implementing communitywide prevention interventions.

A common, and to be expected, tension will be differences between what the community and the researchers perceive to be the priority issues. In most U.S. communities, illicit drug use is identified as a major priority issue; yet, statistics indicate that alcohol-involved trauma contributes more to morbidity and mortality rates. Interviews in all our communities indicate that parents do not regard alcohol use among youth to be of equal concern as illicit drug use. A challenge to this research project, and similar ones, will be how to raise the

salience of the documented problem on the public agenda and respect the community's priorities at the same time.

Economic factors will be playing an increasingly influential role as budget cuts at the Federal, State, and local levels go deeper and deeper. For example, one of our cities has been forced to disband its driving under the influence enforcement patrol; previous research has shown that the perception of increased risk of arrest from drinking and driving provides a major deterrent to that activity. Another community has identified the potential negative impact on the tourism industry (on which its city and county depend) if reduced alcohol access creates the perception that "this is not a fun place to visit!" Both these situations will influence the types of strategies that will be developed within these components.

Working With Multicultural Populations

With the demographics of the United States changing to include a larger percentage of ethnic/racial populations, awareness of and sensitivity to cultural differences will become increasingly important. Many of these communities of color have often had different (and more negative) experiences than White communities with agencies and programs; they feel more vulnerable. For example, many have had negative experiences with the criminal justice system; as a result, interventions that depend on increased law enforcement may be seen as racist, causing these groups to have serious concerns about selective enforcement.

Dialogues with community members have identified a lack of awareness among the majority population regarding heterogeneity in communities of color, reflecting a narrow perspective. For example, the words "Hispanic," "Latino," and "Chicano" are not necessarily interchangeable. Within a specific community they may reflect socioeconomic and political subdivisions that are very value laden; therefore, it would be important to include all segments of the community, from leadership to grassroots, in project efforts. And in communities where ethnic/racial populations are the majority, referring to them as "minority" groups may not be received very openly.

Summary

The following general suggestions on conducting community action-oriented research come from our three communities:

- Develop at the inception of the project communication procedures that ensure regular sharing of information and prevent withholding of information. This step is essential. Though it may require additional effort and working through potential differences of opinion, it will make the road easier to travel in the long run.

- Honor the community's expertise. As one coalition member said to us, "Please 'ping' ideas off us." Explicitly request and solicit community input.
- Keep local staff and community members apprised of all activities *before* they happen; avoid surprises.
- Focus interactions with the community through a central contact, and coordinate research requests to avoid overwhelming the community with competing demands.
- Get to know the community on a personal level. Community people have expressed interest in establishing personal connections with us as people, in addition to the professional and collegial relationships that being involved in a collaborative project brings.

Acknowledgments

Research and preparation of this paper were supported by grant R01 AA09146-01 (H. Holder, principal investigator) jointly funded by the U.S. National Institute on Alcohol Abuse and Alcoholism and the Office for Substance Abuse Prevention.

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Symposium Plenary Discussion

In the discussion period, Sandra Putnam pointed out that two of the three communities in the project described by Harold Holder have OSAP partnership grants, raising the question of how the effects of two programs can be separated in an outcome evaluation. Holder responded that although experience nationwide with partnership activities is somewhat limited, it indicates they will provide a useful community agenda-setting tool, not necessarily confounding any results. "Since ours is an efficacy trial we assumed that the community would be organized, but the form the organization took was not critical....We don't claim that we will be able to parcel out all the various effects on a particular outcome." He said the main question to be answered is whether the community can make a sustained difference. Later it might be possible to untangle the effects.

On the same theme, Fried Wittman pointed out that there are 26 OSAP grants in California, and two of the sites in his study contain OSAP grants and two contain Robert Wood Johnson Foundation grants. He foresees a difficulty in separating out the effects of one project from another, and he believes the notion of control communities may eventually be impossible to sustain.

Tom Greenfield observed that it may be Holder's task to persuade the research field that the existence of an additional grant program in a community is not a confound. He added that there might be a self-selection process at work if a requirement for a study community is that it is already organized for an activity. In a final comment, Holder said he was "not a great fan of control communities" and he was more concerned in this project with "the longitudinal time-series design where we can identify whether we have made a significant effect on the outcome variables we are targeting.... Control communities provide an opportunity to allow for regional or environmental factors that may be confounding the interpretation."

Experiences From the Kirseberg Public Health Project in Malmö, Sweden: An Alcohol Prevention Campaign

Bertil S. Hanson, Stig Larsson, and Eva Lindblad

This paper reports on experiences from the Kirseberg Public Health Project, a pilot project to implement an alcohol reduction campaign in the community of Kirseberg (population 10,000) located in the city of Malmö (230,000 inhabitants) in southern Sweden. The paper presents some experiences from the implementation of the community-based alcohol prevention work with special reference to citizen participation. The importance of social network and social support mechanisms will be discussed in relation to the concept of participation.

Following the policy action taken in December 1987 by the Council of Community and Environmental Health in Malmö, the Kirseberg project was initially set up as an alcohol-prevention project concentrating only on high alcohol consumption as a risk factor (Hanson et al. 1991; Larsson and Hanson 1990). Interviews with representatives of local administrations, organizations, and associations made it clear that the alcohol interventions would need to be integrated into a broader public health strategy. High alcohol consumption should be considered as one of a number of health risk factors. The higher the individual's alcohol consumption, the higher the risk for different types of alcohol-related problems—both medical and social. International experiences of reducing the demand for alcohol also speak in favor of such a public health strategy, which is reflected in the following WHO quotation:

Programs focused only on modifying drinking habits may give very limited results. Experience is now accumulating on the value of incorporating information and education on alcohol problems into broader programs for health and socio-cultural development, involving community participation where possible. General health education is thus seen as a suitable framework within which to develop education programs on alcohol problems (WHO 1980).

The Kirseberg public health project is mainly based on the Anglo-Saxon tradition of "community organization," which is the basis for various community development initiatives (Bracht 1990). Community organization is defined as follows:

A planned process to enable a community to use its own social structures and any available resources (internal or external) to accomplish community goals, decided primarily by community representatives and consistent with local values. These purposive social change interventions

are organized by individuals, groups or organizations from within the community to attain and then sustain community improvements and or new opportunities" (Bracht 1990).

When applied to community health projects the community organization process model provides a structured five-phase guide or process for achieving community intervention goals (Bracht 1990). The first three phases are analysis, initiation-design, and implementation. The fourth phase, maintenance, is intended to make the different prevention programs survive as integrated parts in different administrations' and associations' ordinary activities, even after the project's completion. The last phase is dissemination and reassessment of results and experiences.

The *analysis phase* built the foundation for the prevention campaign. The purpose is to give a picture of the local community's history, culture, geography, demography, and health and health risks as well as its resources. Time spent on this phase is quite important in order to facilitate the planning and design of the prevention campaign. This process is also reflected in this WHO quotation:

Alcohol information and education programs should be based on carefully collected information concerning the sociocultural and economic background of target population, the availability of alcoholic beverages, current drinking habits and problems, attitudes to drinking and consequent problems, and possible constraints on changing drinking behavior (WHO 1980).

The analysis phase showed that the Kirseberg area does not differ remarkably in a demographic sense from the greater Malmö area, except for a higher mortality rate, partly due to alcohol-related diseases (Hanson et al. 1991; Hanson and Romelsjö 1987). The area is rich in public resources, such as a primary health care center, pharmacy, schools, recreation centers, day nurseries, social welfare center, library, municipal service center for retired people, and a church, as well as shops and many employment opportunities. Besides these resources, there are some 60 associations and organizations, everything from sports clubs, local political parties, tenants and tenant-owners associations, leisure centers, and old-age pensioner groups to the local theater group. Interviews with representatives from the local community gave a picture of the local community's different networks, identified local opinionmakers, and showed an interest in a long-term public health campaign that emphasized alcohol. The possibilities of carrying out such a project were also judged to be good. In other words the assessment of community readiness was quite positive (Hanson et al. 1991).

During the *initiation-design phase*, it is important to define the goals for the different prevention activities. While interviewing representatives from the local organizations and associations, a variety of local problem areas was discussed. Alcohol was one of four problem areas identified. Others were

traffic, including noise and air pollution problems; the children's environment, particularly the school safety environment and routes to school; and, finally, problems of loneliness, particularly among the elderly.

Initially, the goals of the alcohol-prevention work were defined by the project leaders. Project goals were further defined after dialogue with representatives from the Kirseberg area. Prevention goals on three levels have been specified.

First, on the level of primary prevention, the goal is to decrease the incidence of alcohol problems and early alcohol dependence through a population-oriented strategy to reduce alcohol consumption by 25 percent by the year 2000. Target focus here includes those groups that are tending to increase their alcohol consumption (women, young people, and less-educated persons).

The secondary prevention goal is to improve early diagnosis of alcohol problems and of alcohol dependency by increasing and developing knowledge, skill, and competence among different personnel groups within the primary health care and the social welfare administration.

The third goal is to improve the effectiveness and coordination of treatment and rehabilitation services in the Kirseberg area. This goal will be accomplished chiefly by seeking new forms of local cooperation between the health care system, social welfare services, and voluntary organizations. We realized early on that it was necessary to include this third goal in order to gain credibility in the prevention work. From an ethical point of view, it is necessary, even in an alcohol-prevention project, to be prepared to take care of those persons who are already alcohol dependent and cannot decrease their alcohol consumption by themselves, and to support children whose parents have alcohol problems.

It is also important to have representatives from the local community committed and willing to take responsibility during the initiation-design phase. We accomplished this goal by involving individuals and representatives from different local associations and authorities early on. In 1989 a resource group within the project was created with about 30 members. Half the members had been appointed by the different local administrative organizations and half by the various organizations and associations in the area. The representatives of organizations and associations were elected at a meeting to which the 60 associations in the Kirseberg area had been invited.

The resource group of the Kirseberg project consists of representatives from local authorities such as the social welfare authority (home service for the elderly, the abuse treatment group, children's day care service), the health service (the primary health care unit, children's health care unit), the school, the leisure center, the library, and the local police. There are also representatives from organizations such as the five residential organizations, three cultural and religious organizations, four sports clubs, local branches of political parties (the Social Democratic Party, the Conservative Party), and the local theater.

The role of the project's university-based organizers has been to inspire and support local involvement and to coordinate intervention activities. It is important that the professional public health organizers of the project bring their expertise into the project by sharing with the resource group their knowledge of and skills in public health issues. This effort needs to be done, however, without taking over the initiative and responsibility for the total project. In practice this involves combining a "top-to-bottom" with a "bottom-to-top" strategy (Peterson 1988). It is important to remember that building a local foundation for a project is a continuous process, and that it takes more time and is more difficult to work *together* with a local community than to steer it from above.

Implementation is based on community participation and a cross-sectional cooperation and partnership between local authorities, local organizations, and other people living in the area. The prevention work is long term, mostly based on resources already in the area, and attempts to reach those objectives defined by the local representatives.

The fourth stage is *maintenance*. In order to maintain different alcohol prevention activities as integrated parts of the different authorities' and associations' ordinary activities, even after the project's completion, these activities must be planned and incorporated as ordinary activities from the beginning. These activities ought to be financed mostly by the different authorities and associations, not solely by external means.

Together with the dissemination and reassessment phase, this five-stage process model has been observed in different prevention programs and has proved successful, but its application should not be considered too mechanically. The five phases are not completely distinct from each other. They have fluid boundaries and can be modified according to local customs and social development traditions. Sometimes the processes described in these phases need to be repeated; for example, by continuing community analysis throughout the life of the project. The analysis and initiation-design phases cannot always be separated. For example, during the interviews with local representatives local health problems were defined, community readiness was assessed, and, at the same time, the process of initiation was started.

It is important in such a complex and multi-interventional program to define both *outcome* and *process evaluation* objectives early. The project's effects on attitudes toward alcohol, alcohol habits, and different alcohol-related problems and disorders are continually monitored by postal questionnaires and registers such as the cause-of-death and inpatient-care registers. Process or qualitative research will document how the objectives of the project were reached and provides the necessary information to stimulate the project's overall development. Community analysis will continue to shed light on obstacles and possibilities for local alcohol-prevention work. One study is dealing with the degree

and nature of participation in the project. The importance of the area's social networks and social support mechanisms will, in particular, be studied.

The process studies show that it has been possible to create a new and active organization in the area and the resource group has increasingly taken over the responsibility and the proprietorship of the project. The participation of the members of the resource group has developed positively but the activity varies within the group. One factor that determines the degree of participation is the extent of *personal or group benefits*. The local authorities attend if participation in the project is important to their own work; for example, through the creation of new alliances between the local organizations and authorities. The local organizations participate in the project according to the benefit realized in relation to quality of daily life; for example, improvements in the traffic environment. Another important factor concerning participation is the sense of *social class affiliation*. Those with a higher education participate more actively than those with a lower education (Lindbladh 1991).

Our experiences from the implementation of the community-based alcohol prevention work can be summarized as follows:

- The five-stage process model should not be considered too mechanically.
- Time spent on the analysis phase is important in order to facilitate the planning and design of the project.
- A local resource group should be formed as early as possible because local anchorage and proprietorship of the project are fundamental.
- The local resource group must be stimulated by combining a top-to-bottom" with a "bottom-to-top" strategy in relation to the professional leaders.
- Be aware of how the power structure and the level of participation develop within the resource group and be prepared to find flexible solutions.
- Local needs for the prevention activities must be created.
- Proceed without haste and do not compete with ongoing activities.
- Be prepared to take care of unexpected needs for treatment, rehabilitation, and support.
- Prevention work requires an ethical awareness among the staff involved.

We have summarized experiences of how to implement and how to achieve local proprietorship and citizen involvement in a local public health project. Now we would like to discuss some theoretical perspectives in relation to the concept of participation in a community-based prevention intervention. For example, important questions to answer are: *Why is community participation important? Is participation a goal or a tool in the local prevention work?*

Community-based prevention intervention can be described in terms of community development or community involvement and it is based on an active participation and partnership strategy between local authorities and citizen groups. In short, citizen action is a key to realizing social goals (Hanson et al. 1991; Larsson and Hanson 1990; Bracht and Tsouros 1990).

The concept of *participation* can be defined as "the social process of taking part in either formal or informal activities, programs and/or discussions to bring about a planned change or improvement in community life, services and/or resources" (Bracht and Tsouros 1990), and *community involvement* as "the active participation of people living together in some form of community in the process of problem definition, decision-making and action to promote health" (Syme 1989).

Community participation is usually viewed as an important tool in efforts to influence norms, values, and living habits as, for example, in the case of alcohol habits (Bracht 1990; Bracht and Tsouros 1990; Syme 1989; Nutbeam 1986). But community participation can also be viewed as an important goal of health promotion. The hypothesis is that an increased citizen participation is beneficial for health per se, because it induces a higher individual control over conditions and demands in daily life, which in turn reduces the general susceptibility of the individual (Cassel 1976). This theory is based on results from research in social epidemiology, especially studies on social network, social support, and health, and is also supported by theories behind the concept of health promotion. Health promotion is defined as "the process of enabling people to increase control over and to improve their health, by identifying and realizing aspirations, satisfying needs and changing or coping with the environment" (WHO 1986).

Research on social network, social supports, and health springs mainly from the field of stress research (Seyle 1950). The individual's relation to his or her environment can be viewed as a dynamic process because the environment is by no means static and therefore requires continuous adaptation by the individual. The individual needs different types of resources to handle demands generated in the environment. Such resources include not only individual ones such as education, personality characteristics, and financial resources, but also social resources—that is, social network and social support (Titmuss 1958).

Prospective population studies show that individuals with low levels of social network and social support have a higher morbidity and mortality in a wide range of diseases (Berkman and Syme 1979; Cohen and Syme 1985; Hanson et al. 1989). Cassel's theory of general susceptibility implies that psychosocial influences in the environment, such as social network and social support, should increase the individual's resistance to pathogenic agents; that is, social ties and relations promote health and protect people against disease (Cassel 1976).

In 1989 Leonard Syme introduced the concept of control as one way for a further theoretical development of the research field on social network, social support, and health (Syme 1989). Control is defined as the relationship between, on the one hand, the demands of daily life and, on the other, the resources the individual has at his or her disposal to handle these demands. Demands represent all types of phenomena that can be potential stressors if they are not handled adequately. Resources are individual ones, and those that the individual has access to through his or her social network. If the resources are sufficient in relation to the demands, there is a high degree of control. The concept of control can therefore be viewed as opposite to perceived stress.

Syme (1989) concluded that the concept of control could be a common denominator in concepts such as social network and social support and also for socioeconomic concepts such as social class, income level, education level, and such. The similarities to the concept of job strain in research on work-related stress and health are also obvious (Karasek et al. 1981). Job strain is a two-dimensional concept, consisting of a job demand vector and a decision latitude vector. Job strain is an important determinant of health, especially cardiovascular disease. Recently Johnson has further developed the original job strain model by adding job support as a third vector (Johnson 1986).

The introduction of concepts such as social network and control can open new and interesting perspectives in the field of health promotion. Citizen participation and control over the conditions and demands of daily life can be developed and strengthened in a community-based prevention intervention. The social network of the individual is the structure through which this control can be developed and the medium through which the health message can be spread. Increased citizen participation and a higher degree of control can promote health in different ways. By participating in prevention work, people can remove obstacles to the development of better health. Such obstacles can be attitudes and lack of knowledge and skills, but health can also be improved by increased control over conditions and demands in daily life, achieved through participation in prevention work, which decreases the general susceptibility of the individual according to Cassel's theory of general susceptibility.

This hypothesis has been empirically tested in a cross-sectional study in the Kirseberg project. In spring 1990 a questionnaire was mailed to 1,500 individuals between 20 and 75 years of age, representing a random sample of about 15 percent of the adult population in the Kirseberg area. The participation rate was 64.3 percent, which could permit considerable selection bias. However, age and gender did not differ significantly between responders and nonresponders. The distributions of background variables, such as age, gender, educational level, foreign background, and cohabitation status, showed a similar pattern to statistics from the City Population Register in Malmö.

The questionnaire contained measures assessing social network, social support, control, and self-rated health and lifestyle factors such as alcohol

consumption. Three different social network measures were used. They were *social anchorage* (belonging to formal and informal groups), *social participation* (degree of participation in social activities), and the "*Modified Alameda County*" *index of social network*, tapping the major domains of social network, such as family ties, contact with friends, membership in organizations, and social contacts in the working environment. One measure of social support was used: *material and informational support*, which assessed access to practical service and material resources and access to guidance, advice, and information. The method to assess the different aspects of social network and social support has been developed and validated at our department (Hanson and Östergren 1987; Hanson 1988; Östergren 1991). *Control* was assessed by a short four-item version of the perceived stress scale, which was described and validated by Cohen and colleagues (Cohen and Williamson 1988).

Self-rated *health* was assessed on a Likert-type scale with seven rungs. The first one represented "very ill health, could not be worse" and the last one "very good health, could not be better." In the analysis bad health was defined as the lower tertile of the distribution. *Alcohol consumption* was assessed by an adjusted quantity-frequency method slightly modified after Armor and Polich (Seeman and Anderson 1983). High alcohol consumption for men was defined as a consumption above 122 g alcohol/week and for women, 105 g.

The results regarding associations between the different aspects of social network, social support, control, and self-rated health and alcohol consumption are presented in table 1.

There are statistically significant associations (adjusted for age and gender) between all the different aspects of social network, social support, and control, on the one hand, and health, on the other. The association between a low level of control and bad health showed the highest odds ratio (OR = 4.8). The analysis of the different social network and social support indices in relation to high alcohol consumption did not show any statistically significant results. However, people with a low level of control more often had a high consumption of alcohol (OR = 1.5).

These results agree with studies by Seeman and colleagues (Seeman and Anderson 1983; Seeman et al. 1988). Powerlessness (low control) was in a prospective study associated with frequent drinking, a higher intake of alcohol, and alcohol problems while social network integration was unrelated to both the alcohol habits and the presence of alcohol problems. As in our study, social network integration did not moderate the relationship between powerlessness and alcohol habits.

The drinking habits in the social network influence the drinking habits of the individual. To be integrated in a social network could therefore mean exposure to persons with a high alcohol consumption. Persons with a low

Table 1. Association between self-rated health and high alcohol consumption on social network measures

Social network measure	n (under the median)	Bad self-rated health OR (CI)	High alcohol consumption
Social anchorage	654 (332)	2.3 (1.6-3.3)	0.9 (0.6-1.5)
Social participation	675 (333)	1.5 (1.1-2.2)	0.8 (0.5-1.3)
"Modified Alameda County" index of social network	616	2.5 (1.73-6)	1.1 (0.6-1.9)
Material and informational social support	664 (318)	1.8 (1.3-2.6)	1.0 (0.6-1.7)
Control	662 (302)	4.8 (3.3-6.9)	1.5 (1.0-2.5)

NOTE: OR = odds ratio; CI = confidence interval.

degree of control could thereby risk increasing their own alcohol consumption. On the other hand, a sense of control can encourage the social learning and flexibility of the individual and make heavy drinking less likely.

The results in this study are based on a cross-sectional study and therefore causality cannot be determined. The results are, however, based on a random sample from the population and could indicate that the concepts of social network and control can be worth discussing in the field of community-based alcohol prevention. The question is whether participation in a local public health project promotes health per se, as well as influences alcohol habits.

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Local Programs and Community Intervention Trials: Developing Coordinated Strategies for Facilitating Action and Integrating Research

Ronald R. Douglas and Norman Giesbrecht

Introduction

Community action research projects and community-based programs may differ in overall intent, style of operation, timetables, links to community groups, and internal evaluation. However, they confront many of the same problems and tend to deal with the same issues. As a result, there is potential for complementary efforts. In an ideal interactive relationship, for example, program experiences provide a basis for generating questions and frameworks that can be explored through community-oriented research projects. In turn, the results from these projects can be disseminated to facilitate more effective programming.

Community Action Research Projects¹

As noted by Perry (1986), the community is a logical focus for alcohol and other drug (AOD) abuse prevention efforts: for these problems are prevalent throughout the community; prevention efforts are seemingly more cost effective in comparison to treatment; as social behavior, AOD problems are embedded within the framework of the community; and this orientation may help us address the underlying causes of AOD problems. For these reasons, there is interest in researching community action projects.

There are six potential generic goals for community action research projects to prevent substance abuse: (1) to test hypotheses and advance knowledge; (2) to encourage and facilitate meaningful community participation throughout the project; (3) to develop and implement interventions in response to the needs and priorities identified by the community members and/or researchers; (4) to enable community members to maintain the developed programs or services; (5) to transfer responsibility for program or service delivery to community members on completion of the project; and (6) to provide frameworks, protocols, and materials that can be adopted for use by other communities. The primary purpose of these projects should be to reduce the prevalence of AOD-related problems and to control the factors that contribute to these problems, and thereby enhancing health. In the authors' view, all other goals are secondary to this purpose.

It is noteworthy that with the exception of goals 1 and 5, these goals are similar to those goals of routine programs or services. However, a major

difference is that while the projects are typically oriented toward testing hypotheses or finding support for or rejection of theories, the programs are oriented toward promoting specific interventions, developing and responding to community needs and interests, and enhancing the response capacity of specific community groups.

The following are some of the key activities involved in realizing the intents of a community action project:

- Developing a project proposal that includes a rationale for the project, criteria and conditions for community involvement, methods for working with the community, monitoring and evaluation strategies, and a rationale for the expected intervention strategy.

- Providing a protocol to define the roles of key players such as researchers/evaluators, local project coordinators and/or community change agents, and community members.

- Developing and conducting needs assessment.

- Defining the key parameters of the intervention because these will need to be taken into account in planning the baseline measures and overall evaluation strategy.

- Obtaining valid baseline, outcome, and interim data.

- Facilitating the implementation of interventions that address the project objectives and are cognizant of the needs and wants of community groups as they emerge from needs assessment and baseline data collection.

- Fostering community participation and providing sufficient local support for training, technical assistance, materials, and other resource requirements.

- Assessing the effectiveness of the program interventions as described by Johnson (1986): formative evaluation to assess materials and community responses, implementation evaluation of program delivery, process evaluation to assess the short-term effects, and outcome evaluation to determine the extent to which previously defined projected outcomes of the project were met.

In looking over these objectives, it appears that, with the exception of the fifth objective (baseline, interim, and outcome measures) and parts of the eighth (evaluation), the key points would also apply to community-level programming. Designing an activity or program, developing a conceptual framework, conducting a needs assessment, preparing an intervention plan, implementing the intervention(s), encouraging community participation and mobilization, and assessing the results of these efforts are clearly key to successful community-based prevention programming.

Key Challenges Facing Community Action Research Projects

Community action research projects are challenging not only in terms of the logistics related to securing support, funding, and managing multiple agenda and components, but also in terms of the more basic issues that must be confronted (see Room 1990).

Some of these challenges include resolving differing perspectives among the key actors; maintaining scientific rigor; achieving the level of community involvement and participation that might have been hypothesized at the outset; and maintaining equity between research and community actions and reporting of results.²

Managing Conflicting Views

As noted, for example in the paper by Graham and colleagues (1990), there are differing, and sometimes incompatible, perceptions and expectations of the main partners involved in community action projects (researchers, change agents, and community members). Divergent priorities are the key underlying reasons for differences among key players. If these differing priorities are strongly linked to different institutions or systems, then it is unlikely that good intentions will overcome the hurdle of differing vested interests.

Researchers may be wary of how the activities of community representatives or change agents will confound research protocol or create unnecessary delays or lead to activities that are not central to the project.

In their quest to establish programs, community members may pay scant heed to research findings and the principles of scientific inquiry. Community members may encourage researchers to condone or support unproved programs and resolve implementation issues on incomplete information (Pentz et al. 1986). The commonly held beliefs of the community, rather than research findings, are often the key determinants of the measures taken in community-based prevention programs (Giesbrecht and Douglas 1990).

Further constraints are placed on the range of possible interventions in that approaches to substance abuse prevention with proven track records of effectiveness are often deemed politically unpalatable by community decisionmakers (Howard and Barofsky 1989). Thus, not only is the project potentially confounded by activities considered inappropriate from a research agenda, but it is diluted in that the potentially more powerful interventions are left behind.

In contrast, community members may view the demands of researchers as confounding their efforts to carry out prevention activities, be frustrated by the extended timetables, or perceive that researchers denigrate the suggestions of community members (Goodstadt 1990).

Community change agents provide advice and services to the community, serve as liaisons between researchers and the local population, and collaborate with both parties in program development and implementation. This arrangement may leave the change agent in a difficult position of having, for example, to negotiate both parties' interests. Also, change agents are likely to be wary of the evaluation process since they may not see key aspects as quantifiable (Graham et al. 1990).

Maintaining Methodological Rigor

Scientific integrity may be compromised by the inherent difficulties of random assignment, the inevitable loss of respondents over time, and political considerations that may make it impossible to include certain sensitive items in a questionnaire or disseminate certain findings.

Determining Level of Community Involvement

Empowering community members with the skills and resources necessary to solve their problems may be considered ideal. However, this empowerment is highly difficult to achieve in practice. There are several reasons for this difficulty: inherently different perspectives on the issue of empowerment; the risk of confounding the research agenda by shifting control to the community institutional agenda; fiscal constraints that do not provide sufficient time to achieve this involvement; and the fact that not all community members have the requisite skills to participate meaningfully. With regard to the latter, community members are likely to feel overwhelmed and incapable of participating and may therefore leave the problem solving to "the experts."

Balancing Research and Programming Resources

Maintaining equality between research and program implementation is vital to generalizing the results from a community action trial. However, this equality may not require an equal sharing of resources, but the appropriate allotment to each. Prevention programming in the community setting provides an option to acquire additional resources from within the community through the process of mobilization, thus permitting limited project funds to be directed to the research activities of conducting needs assessments, baseline, intermediate and post measures, and data analysis. This distribution may be preferred since communities wishing to replicate a successful experimental outcome would not be confronted with a need to acquire large sums of outside funding to launch similar program interventions.

Reporting Results

Publication of results should include a description of the process and interventions as well as a report of outcomes. Traditionally, scientific journals have limited reporting to outcome results, thus making it difficult, if not impossible,

for others to replicate successful interventions. Therefore, so that others may benefit from the community action trial, the project team should publish a description of the interventions in either an internal report or professional journals, magazines, or conference proceedings.

Community-Based Prevention Trials in Ontario

Currently there are two community action projects under way in Ontario that are attempting to prevent alcohol- and other drug-related problems: the Homewood Health Services Comprehensive Prevention Program and the Government of Ontario Anti-Drug Secretariat's Focus Community Program (targeted at youth).

In both projects, because some of the previously discussed challenges have not been met, research appears to be compromised so that the programming can be conducted. Programming philosophy, political considerations, and funding appear to have necessitated these shortfalls.

Both projects subscribe to an integrative program design espousing that singular interventions run in combination with each other and/or sequenced together over time will provide the desired impacts, such as those described by Torjam (1986) and Goodstadt, Simpson, and Loranger (1987). Within the Homewood Program, singular programs are being replicated, modified, or developed for this purpose. Evaluation, however, is focused on assessing each singular intervention as opposed to assessing their combined strength.

Similarly, within the Focus Community Program, individual interventions are being designed and implemented in unison. However, the individual interventions are not receiving the same scrutiny as in the Homewood Program. The Focus Community Program is, however, receiving a process evaluation and measures of perceptions of problems and service gaps before and after the interventions. Although both programs respond to a need to demonstrate that actions can take place in a community setting, neither, unfortunately, will be able to demonstrate that such actions had the desired impact of lowering the prevalence of alcohol and other drug problems in their targeted communities.

Local Programming and Community Action Trials: Are They Complementary?

From trials of community action projects such as the Homewood Program and Focus Community Program, and a review of the literature (e.g., Casswell and Gilmore 1989; Saltz 1988), key challenges for successfully integrating local programming with action research have been identified. As a result, the opportunity to meet these challenges now exists so that local programming can be successfully integrated with community action research trials.

These trials will also produce, particularly in the Homewood Program, refined interventions that could be integrated more readily into a future

comprehensive community prevention design. The Focus Community Program will provide insights for community involvement for incorporation into future designs and a tested needs assessment instrument.

Hard economic times and a need to provide basic health services will have an impact on the design of community action trials conducted throughout much of the 1990s. Therefore, such trials will need to do the following:

- Direct core agency dollars to research to ensure that methodology is maintained.
- Conduct interventions that will contribute to the trial while providing cost-effective services to the community.
- Conduct interventions that do not require large sums of money for design and implementation, but rather secure resources from within a community.
- Implement interventions with a modest cost so that, when proven, other communities can afford to buy in.

These measures will provide an opportunity to involve local programming in a community trial, give cost-effective services to citizens, and address the efficacy of comprehensive integrated prevention programming.

Notes

1. Substantial portions of this section are based on Hyndman and colleagues (submitted for publication).
2. For a more detailed discussion of these and related issues, refer to Hyndman and colleagues (submitted for publication).

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Symposium Plenary Discussion

Eckart Kühlhorn said he was not convinced of the "business idea" of the Swedish project. He noted that some of the resources would be going into treatment and, in his experience, treatment does not produce as many results as prevention. He also noted that women are a target group because they are increasing their consumption, which poses the problem of allowing for network effects, i.e., how women's consumption is influenced by that of their husband or male companion and vice versa. Bertil Hanson replied that treatment was included in the project because of its low budget and the necessity of including people who were going into treatment as a consequence of their trouble with alcohol. He said the influence between men and women was interesting. In health care groups, it has been found that when women decrease their alcohol consumption during pregnancy, their husbands also decrease their alcohol consumption. In response to another question, Hanson clarified the references in his paper to the upper and lower "risk" limits of alcohol consumption. He said anything over 245 grams a week (40 grams a day) by a man and over 220 grams a week (30 grams a day) by a woman would be considered heavy drinking. Anything under half of that amount would be considered no-risk drinking, and any amount in between would be risk drinking.

Rhonda Jones asked Ron Douglas if he could report any successes in disseminating research results to a broader audience including professional groups and the general public. Douglas said outcomes of research by him and his colleagues on municipal alcohol policy formulation have been reported in journals serving the recreational field and in municipal magazines read by politicians. "As a result we have inadvertently been mobilizing the recreation profession and municipal associations into a broader application of the initial pilot studies." He said he would encourage researchers to publish findings in journals and magazines outside their own disciplines.

CHAPTER 4

Special Settings: Needs Assessments or Natural Experiments

Needs Assessments in Mobilizing Community Action

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Evaluation of a Program To Modify Alcohol-Related Knowledge, Attitudes, Intentions, and Behaviors Among First-Year University Students

Jeff Cameron, Paul C. Whitehead, and Michael J. Hayes

Introduction

In recent years concern has grown in a number of university communities that many of the activities available to first-year university students include or revolve around the consumption of alcohol. A related concern is that too few students have been exposed to objective information about alcohol and its effects. These realities, combined with the experiences of late adolescence, first opportunities to live away from home, and the formation of new peer relationships, increase the potential for alcohol problems.

University administrators have struggled with decisions about whether they have the power to control activities involving alcohol and the extent to which they should do so. It has come to be recognized that while there are some activities that can be controlled, there are many others that fall beyond the purview of a university. Efforts have been undertaken to ensure that students have access to information that equips them to make reasonable, appropriate, and measured choices about their drinking (Gliksman et al. 1987). This paper presents the results of an evaluation of an alcohol education campaign that was recently implemented at a university in southwestern Ontario.

The goal of the program was to provide first-year students with information to avoid and reduce the risk of developing alcohol problems. Immediate objectives included an increase in student knowledge about alcohol and the associated risks of consumption, a positive shift in attitudes about drinking and drunkenness, and a positive change in behavioral intentions about alcohol use.

The intervention, primarily print material (five posters, three direct mail brochures to every first-year student, and biweekly advertisements in the campus paper), offered specific guidelines for use of alcohol along with tips and techniques for applying those guidelines. Visual themes conveyed the negative consequences of excessive consumption while the copy imparted the information.

This paper reports on the program for September 1990 to April 1991, the first of three successive campaigns that will be evaluated separately.

Methods

The purpose of the evaluative study is to provide information on the extent to which the intervention is successful in achieving the objectives outlined above. The results of the first year of the program can then be used in a formative way to improve content and delivery in subsequent years. Measurement instruments and the research design are tailored to suit this iterative process.

The choice of research design for this investigation was dictated by two factors. First, it must be recognized that with a campaign of this type it is impossible to select or assign controls from within the study population. It is not conceivable that we might shield control subjects from exposure to campaign materials. Second, given the present popularity of awareness campaigns at other Canadian universities it is neither practical nor possible to select an adequate comparison group of unexposed students. Consequently, we are left to seek approximate methods of controlling the threats to the validity of the study that might, in a more perfect situation, have been eliminated by the use of a control group or nonequivalent comparison groups.

The study employed a variation on Campbell and Stanley's (1966) separate samples pretest posttest design. Survey instruments were administered before and after implementation of the awareness campaign to large ($n = 1,500$) random samples of first-year students. The pretest was distributed to respondents along with university registration materials sent to their homes in August of 1990. The posttest was distributed by mail to their university addresses in March 1991. The composition of the two samples is highly similar. The rate of return was 60 percent on the pretest and 47 percent on the posttest. In a study of university students from the same Province, Gliksman and colleagues (1989) found that there is little difference between the students who respond to such surveys and those who do not. Therefore, we can be confident that the responders are representative of the larger population of first-year students from which the samples were drawn.

The research questions are the following:

- Is there any reason to believe that the alcohol awareness campaign had an impact on levels of knowledge?

- To what extent did students experience changes in alcohol consumption over the course of the academic year? Is there any evidence that might link changes in consumption to the campaign?
- What is the relationship, if any, at pretest and posttest between levels of knowledge and self-reported alcohol consumption?
- Is there any evidence that alcohol-related attitudes have changed during the past academic year? If changes have occurred, how might these be related to changes in levels of knowledge and consumption?

In order to answer these questions, respondents were asked to provide information on a number of dimensions. Alcohol consumption was measured in two ways. First, students were asked to report how frequently they generally consume each type of alcoholic beverage (i.e., beer, liquor, and wine) and how many standard drinks of each they would have on any one occasion. This information was used to derive a measure of average daily consumption that can be expected to be reasonably unaffected by short-term (daily or weekly) fluctuations. Later, students were asked to report exactly how many standard drinks they had consumed on each of the 7 days prior to completing the questionnaire. This information yielded a measure of average daily consumption over the past week. Unlike the first measure, we would expect this measure to fluctuate a great deal with the situational and seasonal experiences of students.

Alcohol-related knowledge was measured by scoring answers to 14 fact-based questions about alcohol consumption and its known effects. The primary indicator of alcohol-related attitudes was derived from a multiple item question that used the semantic differential technique to ask respondents to assess the notions of heavy drinking, light drinking, and abstinence on five dimensions. The dimensions were presented as continua and respondents were instructed to indicate where on each continuum they would rate each of the three notions. The five continua were pleasant-unpleasant, sociable-unsociable, healthy-unhealthy, wise-foolish, and good-bad. In addition to these, we derived an indicator of each student's experience of alcohol-related damage by asking how frequently in the past 6 months they had experienced each of 20 negative consequences.

Results

Compared with pretest respondents, posttest respondents scored slightly, but significantly, higher on the level of alcohol-related information scale. At pretest, the average score was 8.20 out of a possible 14 points. At posttest, this had risen to an average score of 8.54 ($t = 3.28, p < .001$). No significant difference in knowledge score was found between posttest respondents who had completed the survey at pretest and again at posttest and those who had completed it only at posttest. As a result, the overall pretest-posttest difference in knowledge does not seem to be explainable as an artifact of testing.

Finally, among posttest respondents, no significant difference in knowledge score was found between respondents as a function of age. This gives us some confidence in the assertion that the overall pretest-posttest difference in average knowledge score is not simply a product of the fact that posttest respondents were, on average, older than pretest respondents.

An item-by-item analysis of the 14 questions used to generate the alcohol-related knowledge score indicated the following. The observed increase in average scores from pretest to posttest was primarily the result of increases in the proportion of respondents who recognized that having more than 12 drinks per week or more than 4 drinks on any one occasion was associated with increased risk of developing alcohol-related damage. For example, 37 percent of respondents at pretest recognized that the limit on any one occasion should be no more than four drinks. At posttest this proportion had risen to 54 percent. Similarly, at pretest only 29 percent of respondents correctly indicated that people who have more than 12 drinks per week are at increased risk of developing alcohol problems. At posttest the corresponding proportion was 37 percent. The majority of the remaining knowledge items showed little or no change between pretest and posttest.

The study used two measures of average daily consumption (ADC). The first, ADC1, represents average daily consumption in the past 7 days. The second measure, ADC2, represents a more generalized measure, or a measure of average daily consumption over a longer timeframe. Posttest respondents reported significantly higher general average daily consumption (ADC2) and higher average daily consumption over the past 7 days (ADC1) than did pretest respondents. It is entirely possible that the observed increase in average consumption resulted from the great many students reaching the age of majority during the academic year. In fact, although about 33 percent of pretest respondents were younger than age 19, by posttest this proportion had dropped to only 6 percent.

The increases in consumption between pretest and posttest were accompanied by significant increases in the average number of negative consequences experienced by respondents in the 6 months prior to the survey. Pretest respondents reported having experienced an average of 3.2 negative consequences in the 6-month period. At posttest, respondents reported an average of four negative consequences ($t = 4.75, p < .000$).

In both survey administrations we find a weak but significant correlation between scores on the scale of alcohol-related knowledge and average daily consumption, however measured. That is, there is a slight tendency for high scores on the knowledge scale to be associated with lower levels of consumption. For example, among all respondents (i.e., pre- and posttest), knowledge score was associated with generalized average daily consumption with a coefficient of $r = -.11$ ($p = .001$).

Semantic differentials were used to gauge students' attitudes toward heavy drinking (i.e., more than 14 drinks per week), light drinking (less than 8 drinks per week), and abstaining. We found that between pretest and posttest, attitudes toward heavy drinking became somewhat more positive, attitudes toward abstaining became somewhat less positive, and attitudes toward light drinking remained unchanged. Among all respondents, all three attitudes were found to be significantly correlated with both measures of average daily consumption, with the strongest association being the positive correlation between consumption and positive attitudes toward heavy drinking ($r = .52, p < .001$). Consumption was negatively associated with attitudes toward abstinence ($r = -.20, p < .001$) such that those who reported higher consumption tended to hold less positive attitudes toward individuals who choose to abstain. We have already said that we believe increases in consumption are a product of many students reaching the age of majority. It is entirely conceivable that observed increases in consumption predate these changes in attitudes rather than being caused by them. As a final note, we found a slight tendency for high scores on the knowledge scale to be associated with more negative attitudes toward heavy drinking and more positive attitudes toward abstinence. Knowledge scores were unrelated to attitudes toward light drinking.

Discussion

In an earlier evaluation of an Ontario university program with similar elements, Gliksman and colleagues (1987) reported that control respondents (i.e., respondents from another institution who had not been exposed to the intervention) experienced a 50-percent increase in consumption between pretest and posttest. This rate compares with a 4-percent decrease in consumption between pretest and posttest among experimental respondents. In the present investigation (without a nonequivalent comparison) consumption of alcohol among first-year students was found to increase by about 22 percent between pretest and posttest. If we take the 50-percent increase as roughly typical of what would be expected in the absence of intervention, then we might conclude that while the program studied by Gliksman et al. (1987) may have had a greater influence on consumption, the program presented here has still had some impact insofar as it may have limited what would have otherwise been a greater increase in consumption among first year students.

Gliksman and colleagues (1987) also report that, compared with students who were not exposed to the program, those who had been exposed displayed significant positive changes in their level of knowledge about alcohol, in their attitudes about the various uses of alcohol, and in their behavioral intentions with respect to alcohol. Even without the advantage of nonequivalent comparison subjects, we have also observed small but positive changes between pretest and posttest in levels of alcohol-related knowledge. This change does not appear to be a function of prior testing nor does it seem to be a simple

function of the fact that students at posttest were, on average, older than those at pretest. Still, a number of other extraneous factors may account for this finding. For example, some other occurrence within the wider community may have spawned a general heightening of awareness that was completely unrelated to the campus campaign. Subsequent waves of the campaign and their evaluation will put us in a better position to judge whether some or all of the observed increase in alcohol-related knowledge is attributable to the program.

Taken together, the objective indicators included in these analyses seem to paint the following picture. Average daily consumption among first-year students increased significantly over the academic year, probably as a result of the great many students who reached the age of majority between the pre- and posttest administrations of the survey. The increase, however, from a reported average of 1.06 drinks per day at pretest to an average of 1.29 drinks per day at posttest is probably not as great as would have been the case had the intervention not been implemented. This increase appears to have been accompanied by changes in attitudes such that by posttest, heavy drinking was viewed in a slightly more positive light and abstinence was viewed in a slightly more negative light. Attitudes toward light drinking were unchanged. It is probably plausible to expect that the attitude adjustments were a reaction to increased consumption rather than a cause of it. In summary, affirming evidence for the success of the program is somewhat speculative.

Another source of data available to us, however, presents a more promising picture. Posttest respondents were asked to respond to a number of questions about their awareness of and reactions to the program. Fully 97 percent of respondents reported that they could recall having seen at least one of the elements of the media campaign. Of these, 70 percent said that they recalled having seen posters,¹ 19 percent said that they had seen pamphlets, and 9 percent said that they had seen both posters and pamphlets. Exactly half of the respondents who recalled some element of the campaign said that they had, at some point, discussed the messages with members of their family and/or with friends.

Just over a third of the respondents reported that their reaction to the campaign and its messages was neither positive nor negative. The majority, 60 percent of all respondents, said that their reaction was either positive or very positive. Less than 2 percent reported having had a negative or very negative reaction to the campaign. Despite this, however, 38 percent of respondents felt it unlikely or very unlikely that the campaign would have any impact on their attitudes toward drinking and drunkenness. Half (51 percent) of all respondents believed that it was unlikely or very unlikely that the campaign would have any impact on their behavior. From a more positive angle, 35 percent of respondents believed that it was likely or very likely that the campaign would affect the way they thought about drinking. Twenty-two

percent believed it was likely or very likely the campaign would affect their behavior.

Summary and Conclusions

Subjective indicators frequently provide less than perfect information regarding the effectiveness of interventions. In this case, however, the subjective data reinforce our belief that the increased knowledge suggested by objective indicators is, indeed, attributable to the awareness campaign. In addition, the subjective data assure us that the campaign messages are reaching program targets and are, for the most part, being received favorably. This type of process information should provide some confidence as we move closer to the second wave of the program, for which an increase in intensity is planned.

Note

1. Two thousand posters were used, but this should not be taken as reflecting that there were posters in 2,000 locations. The posters regularly "disappeared" and had to be replaced. Perhaps the high rate of sightings included locations such as rooms in student residences.

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Prevention Strategies in the Workplace: Experiences From Five Workplace Needs Assessments

Scott Macdonald and Samantha Wells

Introduction

In this paper, obstacles to promoting prevention programs are described and possible means to overcoming these obstacles are put forward, such as the use of needs assessment surveys. The purpose of and processes related to conducting needs assessment or employee surveys at five workplaces are described in this paper, as are the results of the employee surveys. Information and insight gained from carrying out these needs assessment surveys are also reviewed.

Strategies for Encouraging Workplaces To Adopt Health Promotion and Prevention Programs

One major difficulty in promoting health promotion and prevention programs in the workplace or within other community group settings is convincing parties of the value of such initiatives. Employers are not inclined to recognize and acknowledge the worth of health promotion/prevention programs. Many individuals find the idea of preventing problems that *may* occur somewhat obscure and ambiguous. Another difficulty in promoting prevention and health promotion programs stems from the fact that such programs appear to be less likely than other programs to produce immediate tangible results because their impact is usually incremental. In addition, the health promoter/researcher is unable to identify *who* will be prevented from encountering health-related problems. It is therefore not surprising that employers often delay or avoid implementing prevention programs.

In contrast, treatment programs are easier to promote and evaluate. For example, when an individual clearly requires treatment, on-the-job performance is often poor. The employee might be frequently late or absent from work or have difficulties getting along with his or her supervisor or coworkers. Company representatives can easily see the value of eliminating or decreasing the frequency of such problems. When the reduction of these problems is reported and recognized on treatment, evidence that the treatment program is effective is supported. Furthermore, when treatment programs are employed, the company can identify, to some extent, who will benefit from the intervention. Thus, tangible results are produced that demonstrate to the employer that the implementation of such programs is worthwhile and profitable.

The importance of developing effective strategies to persuade workplaces of the usefulness of prevention/health promotion programs should not be undervalued.

One method of overcoming difficulties related to promoting the use of such programs might be to avoid labeling them according to program type (i.e., treatment, prevention, or health promotion programs) and to speak in terms of specific programs. As such, needs assessment studies can be carried out to determine what specific programs might best meet existing workplace needs without biasing the employer toward or against program types. Furthermore, employers can usually recognize the value of concrete, specific programs. For example, employees at a company might indicate a need for a smoking cessation program. The employer is likely to see the value of implementing such a program, regardless of whether it is a prevention, health promotion, or treatment program, because employees will benefit from the reduced risk of lung cancer, heart disease, and other associated ailments, and it is widely believed that, because of absenteeism, healthy employees are far more likely than unhealthy employees to be productive in the workplace.

Another strategy for promoting the development of prevention programs involves the implementation of needs assessment studies in the workplace. Needs assessments that determine priorities for program development and improvement can be extremely useful mechanisms in changing attitudes toward prevention and health promotion.

Needs Assessment Surveys

Needs assessment studies in workplaces involve the administration of a questionnaire to every employee in a company or workplace. Such surveys can be very useful for providing information to organizations interested in establishing or revising employee assistance programs (EAPs) or workforce health programs. More specifically, they can be particularly useful when one is attempting to achieve any or all of the following objectives:

- To determine the preferred structure for a new EAP.
- To determine improvements for an existing EAP.
- To determine priorities for programming.

Employee surveys can also serve to foster a democratic process wherein all employees feel they are contributing to work force programming decisions. If an EAP already exists in the workplace, these surveys often help to promote knowledge about its existence and increase awareness about health-related issues.

Needs assessment studies can be implemented concurrently with evaluations of EAPs or studies that are designed to determine the preferred structure of EAPs. In Ontario a significant proportion (about 16 percent) of large companies have EAPs. Generally speaking, companies support the idea of implementing and improving EAPs and correspondingly endorse studies designed to evaluate how well their EAPs are performing and to determine what other

programs should be implemented to suit their workplace needs. Questionnaires administered to all employees may contain questions that pertain to the performance of the existing EAP. Other questions can be included that pertain to lifestyles and preferred areas of programming. These questions can be used to determine areas of high need and the most effective ways of meeting those needs.

Once the needs of the company have been determined, other questions can be added to address more fundamental research questions. The type of information that companies are particularly concerned about might also be useful for research purposes. For example, a number of workplaces in our needs assessment studies required information about the extent of lifestyle problems, such as smoking, alcohol and other drug use, and stress levels. This information was useful for developing a variety of programs, including prevention and health promotion programs. Also included were questions about employees' job characteristics, which were useful for targeting various programs. These job-related questions were also instrumental when it came to examining the relationship between job characteristics and alcohol and other drug use. This kind of information will be used to determine what kinds of programs need to be established within different employment settings, so that job-related alcohol and other drug problems can be prevented. Data obtained from each workplace study were combined to form a large database. These data will be analyzed in order to fulfill these research objectives.

Another important ingredient for obtaining support from companies to conduct this kind of study is to develop a longstanding relationship with companies. The Addiction Research Foundation (ARF) is unique in that it has 27 offices throughout Ontario, with program consultants devoted to disseminating information about alcohol and other drugs to interested parties, including workplaces. These program consultants have, over the years, developed relationships with EAP coordinators and committee members from workplaces, which are invaluable for fostering mutual respect and trust.

Methodological Problems Associated With Workplace Needs Assessment Studies and Suggested Approaches to Overcoming Problems

Companies are usually not interested in having research conducted when their own employees are used as a sample unless direct applications of the research are envisioned, such as the development of programs and policies that will benefit the company itself. Providing a service for companies is critical to cultivating a good working relationship between employers and researchers. Both parties benefit in this situation—the employer can address employee needs in the workplace and the researcher can address his or her own research objectives. Charging companies for the survey appears to improve this relationship because it increases the employer's sense of ownership over the product.

When needs assessment studies are conducted in workplaces it is very important to obtain some form of commitment from employers. They must be committed to supporting the research process as well as following up with tangible policies or programs based on the results. If a needs assessment study is conducted that produces results pointing to a high need area, and nothing is done to meet this need, then morale and productivity may be reduced. Management should be encouraged at the outset to allocate monies towards improved or new programming. Until such a commitment has been made, it is usually not worthwhile to proceed with a needs assessment study.

When the impetus for conducting needs assessment studies comes from EAP coordinators or EAP committee members, the likelihood that prevention and health promotion programs will be initiated is usually increased. These people are often more committed than executives and managers to the principles behind maintaining good social, physical, and mental health among employees. Consequently, EAP coordinators and committee members become advocates for such principles and programs. It is their role to convince management that needs assessment surveys are valuable in determining high need areas for employees.

Experience gained from conducting five workplace needs assessment studies suggests that two factors are crucial to determining whether new programs will be implemented: who makes the initial request for the implementation of a needs assessment study and the level of commitment by management to follow up on research results and recommendations. In three of the workplaces studied, EAP committee members initiated the implementation of a needs assessment study and management indicated that they were committed to following up the results with program development. Each of these workplaces subsequently adopted new programs. In contrast, at another company under study, the union made the initial request for a needs assessment study as part of a collective bargaining agreement. Notably, not one new program evolved from the process. In the fifth company under study, management initiated the implementation of a needs assessment study. This company was severely troubled by low morale and a number of other employee problems. Some departments within this company boycotted the questionnaire, resulting in a 28-percent response rate. This company also had a history of conducting employee surveys and failing to act on the results. Unfortunately, this pattern continued; no new programs were initiated following completion of the needs assessment study.

It was also discovered through the implementation of these studies that it is critical for the EAP committee to be actively involved in the process of data collection; otherwise, a low response rate may result. A low response rate could create considerable systematic bias as respondents might be substantively different from the employee population as a whole. Response rates can be improved by ensuring that information about the forthcoming survey is provided to all

employees by the EAP committee. Detailed followup procedures should also be implemented. These procedures can be carried out successfully by EAP personnel because they are typically respected and highly regarded by employees.

Response rates can vary considerably and are largely dependent on procedures used to collect the information. Before the data are collected employees should be informed about the purpose and value of the upcoming survey. This task can be accomplished through several strategies: letters to employees, flyers, information sessions, posters on bulletin boards, and announcements on public address systems. Generally, 1 week is sufficient for employees to complete the questionnaires. The highest response rates are achieved when questionnaires are administered to employees during the workday and employees are given time during working hours to complete them. Most companies are reluctant to use this approach, however, because they believe it is disruptive. Another effective approach to increasing the response rate is to have key persons in each department of a company responsible for collecting data. With this method, key personnel can make a note of who responded and encourage those who did not respond to fill out the questionnaire. Alternatively, all employees within that department can be reminded by department personnel on several occasions to participate in the study. However, companies are sometimes reluctant to involve department personnel in the collection of questionnaires because confidentiality can be violated. Some workplaces have a multicultural work force and, therefore, language and cultural barriers can pose serious problems for data collection. If a significant non-English speaking group is identified, translated posters, announcements, and survey questionnaires should be used to increase the response rate and reduce data collection problems. Response rates of 50 percent to 70 percent are typical when many or most of the above procedures are carried out.

Results From Five Workplace Needs Assessment Surveys

Surveys were conducted at five different worksites: a police force, an industry (oil refinery), a food service company, an educational institution (maintenance workers), and a hospital. Selection of worksites was not based on random procedures. Rather, organizations wishing to conduct employee surveys requested assistance from ARF community consultants. Survey results were very useful for determining program needs. For example, results from the police force survey indicated that exercise, weight and nutrition, and stress were important concerns among police members. Therefore, health promotion, fitness, stress management, and weight/nutritional counseling programs were recommended. The service company under study had both a high rate of cigarette smoking and an interest in participating in a smoking cessation program; a smoking cessation program was recommended. Employees at the oil refinery indicated a high level of stress, a high need for financial planning, and a high level of interest in fitness. Consequently, stress management, financial planning, and fitness programs were recommended.

The results of these surveys indicated that respondents in workplaces with EAPs had low utilization rates and low awareness of the procedures for using the EAPs. Therefore, EAP promotional campaigns were recommended. At each workplace employees were asked their preferred location for treatment, either on or off the worksite premises. An overwhelming majority of employees at all workplaces preferred off-site treatment services, so off-site locations were recommended.

Information was also obtained about the effectiveness of EAPs in workplaces. Employee feedback can uncover severe EAP implementation problems and consequently produce dramatic changes in implementation. For example, in a recent needs assessment study and EAP evaluation, employees who used the EAP made serious complaints about their EAP coordinator. This EAP was an on-site program where all forms of treatment were conducted by this one individual. Many employees who sought treatment reported in lengthy open-ended comments that the coordinator was unprofessional and had breached confidentiality. These comments were appended to a report with recommendations for off-site treatment by professional counselors. Upon reading the report the EAP coordinator endorsed the recommendations and off-site treatment was established. The coordinator was transferred to another position within the company.

Conclusions

Many obstacles impede establishing health promotion/prevention programs and conducting research on employees in workplaces. Strategies can be adopted to overcome these difficulties. First, we have found that it is best to establish a common link with companies, which usually involves a needs assessment study designed to assess how an EAP might best be improved or developed. Second, discussing tangible programs rather than concepts and program types (i.e., treatment or prevention) appears to be an effective way of dealing with problems associated with "selling" health promotion/prevention programs to companies. Third, developing a longstanding relationship with companies is very important. At the ARF this component is met by program consultants in 27 field offices throughout Ontario. Finally, in order for the needs assessment research process to be successful and produce optimal results, EAP committees and management should be committed and actively involved in every step of the process.

Symposium Plenary Discussion

Jeff Cameron was asked how he involved young people in the design of his project. Cameron said students were included in the steering committee formed at the outset of all projects and provided their thoughts on the design. Brad Zipursky asked if there had been any work with focus groups to find out why some people failed to "get" the program. Cameron said the budget did not allow for focus testing.

Sandra Putnam asked Scott Macdonald to discuss ways of overcoming difficulties in asking smaller companies to develop EAPs that may be more than they can afford. Macdonald said one solution is to form consortiums, such as a group of 10 companies with 50 employees each forming a pool of 500 employees and allowing the companies to share the cost of the program. Norman Giesbrecht wondered how an EAP could be made appealing to sectors that might not see employee problems in the same light, such as management and labor unions. Macdonald said management might be willing to support an EAP as a means of controlling absenteeism and truancy and improving productivity, while the appeal to unions would be based on their traditional concern for worker rights, morale, and humanitarian issues. He explained how information from the needs assessment is used to help employers or program consultants determine whether to have on-site or off-site programs. The study group hopes to develop a self-help manual for employers that would cover this process.

Naturalistic Observation: Prevention Research Opportunities

The Celebration of Midsummer Eve in Borgholm: An Example of Effective Alcohol Use Prevention

Jill Björ, Johannes Knutsson, and Eckart Köhlhorn

Introduction

Primary prevention in the field of alcohol is focused on drinking itself, often with the aim of avoiding long-term effects on health. There are, however, also short-term effects caused by excessive drinking. Swedish experiences—historical as well as more recent—have shown alcohol to be a critical factor in collective disturbances and similar events. In such settings the main problem consists of a combination of crowding, expectations about opportunities for violent behavior, and the consumption of alcohol. For the general population and for authorities who maintain public order, these types of events play such a role that they should be included in an alcohol use prevention concept.

The study of disturbances of this kind is often problematic because the occurrence is usually hard to predict. Thus most such incidents are studied retrospectively. In Sweden people who have been arrested in the course of such events have been studied and, indeed, information about the identity of these individuals is practically the only systematically obtained information available. A common finding is that individuals with a prior criminal record are overrepresented among those who participated in the disturbances.

The limited nature of available data, as well as infrequency of these events, makes the evaluation of countermeasures very difficult. A successful retrospective study was undertaken by Köhlhorn (1978) who studied police action in response to the occupation of a centrally situated park in Stockholm by groups of drug abusers in the beginning of the 1970s, with an associated increase in crime and disorder in the park and the neighborhood. The police enforced the Temporary Custody Act against the occupants and succeeded in restoring order in the park. By comparing crime trends from adjoining areas, eventual displacement effects were studied. It was concluded that some displacement effects had occurred, but that overall the problem had diminished.

Another way to study the effect of countermeasures is to focus on situations that experience has shown to be critical and that occur with reasonable predictability. The celebration of Midsummer Eve in Sweden is a phenomenon that can provide such opportunities.

A major methodological problem in studies of this kind is to develop methods of data collection that are independent of the measures taken by the authorities. In an evaluation strategy, an arrest for drunkenness is both a result of drinking and a measure taken by the police—cause and effect are mixed—and the opportunities to make conclusions about effectiveness are limited. Therefore, experience and knowledge about more appropriate methods for data collection, as we have tried to gain in this study, are necessary conditions for improving research.

The Celebration of Midsummer Eve

The celebration of Midsummer Eve has its roots in the agrarian traditions of Swedish society. It has traditionally been connected with sexuality and the consumption of alcohol. That it also caused trouble in the past is shown by a 17th-century prohibition against raising maypoles.

Well-developed communications systems in modern society mean that it is easy for people with certain traditions of celebrating Midsummer Eve to get together. In some parts of Sweden large crowds gather and threaten public order with disorderly and drunken behavior. The participants are mainly recruited from certain groups of young persons—so called *raggare*—who have a particular interest in large American cars. The police have been forced to mobilize considerable resources in order to control the situation in the places concerned.

Location of the Study

One such place is Borgholm, a small idyllic town on the island of Öland in the Baltic Sea. It is a typical tourist city with about 11,000 residents. The main street, where a substantial part of the celebration takes place, is a couple of hundred yards long. Most of those taking part stay in camping sites in the surrounding area during the holiday of Midsummer Eve. Since it is impossible for the local police to handle the situation, they are temporarily reinforced by other forces. One of the larger police districts contributes a detachment of mounted police.

The Study

The event was studied in 1987 by participant observation by one of the authors (Knutsson 1987). Because the police managed to make the local authorities take preventive measures in the following year, the study was repeated in 1988 (Knutsson 1988). In order to study changes in the crowd's state of sobriety, a method using systematic social observation was developed and used in 1988. Some local groups opposed the measures the police wanted to introduce, probably fearing negative economic consequences. This conflict was studied by interviewing different key persons from the local community.

Before the Intervention: The 1987 Celebration

The celebration started the day before Midsummer Eve and lasted for 3 days. Before noon on the first day drunken young persons appeared on the main street. As the day continued, the town center became increasingly crowded with very drunk young men. The police patrolled the streets and picked up those persons who were unable to take care of themselves because of intoxication and placed them under custody in the local police station. Because of the limited capacity of cells, each usually contained several persons.

The real feast occurred on Midsummer Eve. The participants started with drinking parties on the camping sites. Some slept in their cars in the parking lots and began their drinking there. When they were thoroughly intoxicated, they went into the city, often bringing bottles that, when emptied, were thrown on the streets. As the day wore on, piles of broken glass accumulated.

At the height of the celebration, thousands of persons roamed up and down the streets. During the culmination of the celebration late on Midsummer Eve it was hard to move in the center because of the crush of people. The atmosphere was charged and the event could have developed into a riot. The police decided to take forceful action in order to break up the crowd. They made a "wedge" to march into the crowd: First came the mounted police and after that police on foot, followed by police buses, where intoxicated persons and those arrested for disorderly conduct were held. Even though the situation was very tense, the police succeeded in keeping order and the crowd dispersed.

Celebrators With Police Contacts

A check of the 230 individuals with police contacts because of drunkenness, disorderly conduct, or crime showed that they were young (on the average 23 years of age, median 21 years), male (only 4 percent female), and frequently had a prior record of criminality (see table 1).

Table 1. Proportion of persons with prior record of serious crime among those with police contacts during the Borgholm celebration due to intoxication, disorderly conduct, or crime

Age	<i>n</i> *	Proportion with prior record of serious crime	Expected values	Over-representation
15-19	49	18%	7%	2.6
20-24	119	24%	11%	2.2
25-55	62	53%	15%	3.5

*Including 9 women

It can be seen from table 1 that there was an overrepresentation of those with prior known serious criminality of a factor between 2.2 and 3.5. This result is consistent with other Swedish studies on public disorder.

The Intervention

In 1987 the event was mainly controlled with traditional measures, e.g., intensive patrol by the police and arrest of drunks and people behaving in a disorderly manner. A "rule" that stipulated a ration of alcohol was introduced. Presumptive visitors were informed they could bring only one bottle of hard liquor and 24 cans of beer per person. The rule had no legal foundation but it was heavily publicized in the mass media.

The measures introduced the next year consisted of refusing to accept the *raggare* at the camping grounds and closing parking lots near the center of the city. The police convinced the local community, responsible for these arrangements, that these measures would be effective. Initially, the proposals were met with resistance, but this was overcome when the police applied some pressure making community cooperation a condition for their continued effort.

In addition, the police declared the celebration a "public event." During such an event, individuals are forbidden to be in possession of alcohol and to carry knives. In both years the consumption of alcohol was forbidden in public places.

These measures are of a situational nature (Clarke and Mahew 1980). They have a collective orientation in the sense that all in the perceived high-risk group were affected. A drawback of the measures is that even law-abiding individuals in the group were affected.

The police activities were within the definition of problem-oriented policing (Goldstein 1990) because they went beyond the traditional way of handling a matter that society has defined as a police problem, and compelled those who can have an impact on the problem to act.

After the Intervention: The Celebration in 1988

During his initial briefing of the force, the chief of police underlined that the local community had changed its attitude. He stressed the importance of the newly introduced measures—especially blocking the camping sites to *raggare* and closing parking lots. The first task for the police was to ensure that these rules were followed.

As a possible result of media publicity, fewer people went to Borgholm than in the year before. The expected trouble with the *raggare* did not materialize. Those who tried to enter the camping grounds were simply sent away, and the police tried to track their movements with a helicopter. It was believed at the time that some went back home when they realized that they could not have

their fun. Later during the night, however, a site outside Borgholm was found that had accepted *raggare*. Some of them had ended up there and the familiar scene of drunken and misbehaving young people all over the place could be observed.

Even though many people were drunk in Borgholm in the 1988 celebrations and many were arrested by the police, the situation was radically changed for the better. This fact is not apparent when the numbers of people arrested for drunkenness are compared (see table 2). However, there was a sharp decline in the number of persons arrested for disorderly conduct—arrests usually stemming from confrontations with the police.

Table 2. Number of persons arrested for intoxication and disorderly conduct in Borgholm, 1987 and 1988

Year	1987	1988
Intoxication	131	120
Disorderly conduct	42	15

Systematic Social Observation

A part of the main street was observed hourly from 11 a.m. to 3 a.m. on Midsummer Eve 1988. The proportion of persons showing signs of intoxication grew from about 5 percent to a maximum of 40 percent in the evening. The number of young people in the 13 to 25 age group increased during the event and when the celebration reached its climax, more than 80 percent were of this age group. About 40 percent were women.

An estimate of the number of persons and those showing visible signs of drunkenness in the center of Borgholm was made on the basis of the observations (see table 3). It can be seen that at the height of the festivities between 3,000 and 7,000 persons, of whom about 900 to 3,000 appeared to be intoxicated, were to be found in the center of Borgholm. Of those, only a fraction were arrested because of intoxication.

The Interview Study

Altogether 34 key persons from Borgholm were interviewed. They represented different functions and interests in the local community and were divided in two groups: those who had an interest in promoting the celebrations (generally local businessmen) and those who did not.

Table 3. Estimated maximum and minimum numbers of participants, people showing signs of drunkenness, and number of persons arrested for drunkenness, Midsummer Eve 1988

Hour	Participants		Intoxicated		Arrested for drunkenness
	Min	Max	Min	Max	
11-13	1,050	3,000	15	540	1
13-15	150	1,650	3	33	2
15-17	0	3,000	0	480	5
17-19	150	1,950	2	468	5
19-21	0	1,500	0	120	15
21-23	3,000	7,050	870	2,961	21
23-01	2,550	5,550	638	1,665	18
01-02	1,050	2,400	189	351	9

A similar proportion in both groups agreed that the decision to block the camping grounds for *raggare* was not discriminatory. However, those with an interest in attracting visitors were more likely to believe that local businesses took economic losses. They also showed a tendency to be more negative about the activities of the police and, as a group, were more likely to feel that the police went too far in their efforts to control the celebrations. But nearly all, irrespective of their biases, agreed that the situation had changed for the better (see table 4). Thus, their judgments are in accordance with the opinion of the celebration observer.

Table 4. Opinions of 34 key individuals concerning the Midsummer celebration in Borgholm in 1988 compared with 1987

Problem area	Better	No change	Worse	No view
Drunkenness	31	2	0	1
Accidents	29	1	0	4
Public order	29	3	0	2
Vandalism	29	4	0	1

Conclusions

In a situation where it is culturally acceptable to drink excessively—such as during Midsummer Eve celebrations in Sweden—there will always be some individuals who exceed the bounds of acceptability and become a threat to public order. This was the case in Borgholm for a number of years, where the tradition of celebrating Midsummer Eve had regularly attracted large numbers of people prone to disorderly behavior.

As a result, the police were faced with a difficult situation and, in seeking to prevent a repetition in 1988, the police took two important steps. They strengthened controls pertaining to the consumption of alcohol during the celebrations, and they excluded some potentially troublesome groups from the town. These measures, along with considerable media publicity, improved matters quite substantially.

The persons affected by these measures did not become “better,” but the negative consequences of a concentration-effect—a lot of drunken individuals in one place—were avoided. Problems connected with the celebration of Midsummer Eve will probably appear in the future. However, there are no signs, so far, that those interested in a degenerate celebration have found new places to go.

The police measures taken in Borgholm provide a further example of the way in which a situational prevention approach can result in the effective management of a problem of drunkenness and public disorder (see also Ramsay 1991). Experience at Borgholm provides evidence of the particular value of excluding troublesome individuals from potentially explosive situations. These measures focused on a group that, according to tradition, is considered weak because of age and socioeconomic status. But is it reasonable to look upon them as weak in this situation? Many inhabitants left Borgholm during the event because they could not stand the disturbance.

Our experience has shown systematic social observation to be valuable in evaluations. In situations where effects are not as great and visible as in our case, it gives sensitive data. Furthermore, in comparison to a commonly used measure—arrest for drunkenness—the information is independent of the acting organization. Technically, the method is not easy to apply and is rather expensive, but it gives reliable data according to the criterion of agreement among observers. As to validity, it is not possible to tell if all those classified as intoxicated really were. They may have tried to appear inebriated to live up to group expectations. In this case it constitutes only a minor problem since our focus was on behavior and its consequences.

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Spring Break, Alcohol Promotions, and Community Responses

Barbara E. Ryan and James F. Mosher

Introduction

Spring break is an annual event for U.S. college students who, weary from courses and cold weather, travel to warm climates for a week or two of vacation that has become synonymous with heavy drinking and partying. In some cases cities have promoted themselves as spring break destinations in order to generate revenues during what is generally an off season for many resort communities. However, the increased business is often associated with problems related to heavy alcohol use, including vandalism, rowdy behavior, riots, trauma, and death.

At some spring break sites large corporations participate in student expositions so they can market products to a relatively affluent population that is developing lifelong brand preferences. Until recently the beer industry maintained a strong marketing presence during spring break. But criticism of the beer industry's marketing tactics began to emerge in the mid-1980s. By 1991 problems remained so severe that the U.S. Surgeon General Antonia Novello publicly requested that the alcohol manufacturers and retailers "take a more responsible posture with regard to their marketing and promotion tactics during spring break." Novello also said that for our young people "it is time to 'Put on the Brakes' with regard to their drinking" (Novello 1991).

The brewers have moderated their promotional activities in response to the initiatives of fed-up resort communities. In recent years spring break destination communities, including Fort Lauderdale, Florida; Daytona Beach, Florida; South Padre Island, Texas; and Palm Springs, California, imposed controls in an effort to reduce the problems associated with spring break revelers. Controls range from bans on beer-sponsored beach concerts to restrictions on the posting of brewers' banners on the exteriors of buildings. The brewers claim that they would be changing their marketing activities even without community pressure (Big brewers will be among wallflowers 1991).

In response to the Surgeon General's call for restraint and common sense, the *Birmingham News* reported that "in theory this is the Spring Break that changes Spring Breaks." The paper noted that the 100-foot beer banners and dancing beer cans are gone from Daytona Beach, and "all that's left are the Miller Girls. And the Bud Paradise Spring Break '91 posters. And the Bud Paradise banner that gets towed behind an airplane every afternoon" (Spring breakers 1991).

Changes in the marketing practices of the alcohol industry have occurred in the last 2 years. As recently as 1989 Anheuser-Busch and Miller published glossy, full-color advertising supplements for campus newspapers promoting spring break activities at various destinations. Anheuser-Busch's eight-page Bud Beach Club urged students to check in at Bud Beach Clubs—spring break's hot spots—at Daytona and Fort Walton. Students were issued membership cards to get into the Bud Beach Club, Bud jam sessions on the beach, volleyball tournaments, and the "world's largest water fight," as well as win such Bud Beach Club merchandise as T-shirts, beach towels, and water guns. But Miller's 16-page "Beachin' Times" raised a cry of protest from students, including threats to boycott Miller products by the 44,000 students at the University of Wisconsin at Madison unless Miller pulled the ad and apologized. Students complained that the ad was insulting, puerile, and sexist, with features like "4 sure ways to scam babes" and "Why I am a college student." Like Anheuser-Busch, Miller promoted its spring break headquarters, Miller Oasis, in Daytona Beach and South Padre Island (Beer ad's humor falls flat 1989).

In 1990 brewer-sponsored promotions at spring break sites continued, including a two-story inflatable Budweiser six-pack on the beach at Daytona where employees handed out Bud T-shirts and hats. Criticism of the brewers' marketing practices also continued. Federal Trade Commission (FTC) Chair Janet Steiger said, "I question whether [some] college campus and spring-break promotions can be so finely tuned as to effect, or encourage, drinking by only those college students who are of legal drinking age" (Spring break messages draw fire 1990). According to the *Washington Post*, spurred by similar concerns, Representatives Thomas A. Luken (D-Ohio) and Bob Whittaker (R-Kansas) asked the FTC to review measures "to achieve industry-wide changes in the marketing of alcoholic beverages" (Spring break messages draw fire 1990).

Although the threat of restrictions has in part prompted the industry to shy away from its more aggressive marketing tactics, according to *Advertising Age* (March 1, 1991), Anheuser-Busch, Miller, and Coors said they were not totally out of spring break activities, but promotions were more retail directed and aimed at people over age 21. Suzanne Smith, director of Daytona Beach's Spring Break Festival Task Force, said that beer companies "have voluntarily pulled back over the last two years." She explained that "what's going on is part of a national trend, not only in alcohol but in sex, drugs, and the environment" (Spring break 1991). Rob Klugman, vice-president for brand marketing, said that Coors decided to cut back on spring break marketing 4 or 5 years ago. He said, "We looked at major spring break activities and decided that in the long term it was not smart" (Spring break 1991).

To observe alcohol industry marketing and alcohol-related problems during spring break 1991, OSAP sent two staff members to Fort Lauderdale and Daytona Beach (Spring Break '91 1991). In addition, staff from the Marin Institute for the Prevention of Alcohol and Other Drug Problems traveled to

two popular West Coast destinations to collect information on alcohol industry marketing related to spring breaks and community responses to reduce problems (Ryan and Mosher 1991).

Fort Lauderdale, Florida

Fort Lauderdale has been the site for large student gatherings during spring break since the late 1950s. As the location for the 1960 movie *Where the Boys Are*, which institutionalized spring break as a bacchanalian event that stressed beer, beach, and bikinis, Fort Lauderdale received national attention. By 1985 Fort Lauderdale had become so popular that the student crowd had mushroomed to an estimated 400,000 over a 6-week period, placing a burden on police, sanitation, and beach services. Many, including a sizable portion of the business community, felt that spring break had gotten out of control.

Following spring break 1985, the city convened a task force to examine the problems that, in its view, had resulted in a tarnished image of the city caused by out-of-control spring breakers. The task force included local government, the business sector, the chamber of commerce, and citizen groups. New policies included active enforcement of open container ordinances and stepped-up efforts directed at crowd control, including erecting barriers between the streets and sidewalks. As a result of the changes Fort Lauderdale lost much of its appeal to students, who sought new spring break locations. Crowds were reduced to an estimated 18,000 to 20,000 in 1991. The shift away from Fort Lauderdale by students in response to controls occurred about the same time that Daytona Beach began expanding spring break activities to recruit students and generate revenues.

Daytona Beach, Florida

Although Daytona Beach has hosted spring break activities for a number of years, it was not until 1989, with the shift from Fort Lauderdale, that the city had massive crowds. More than 350,000 people showed up in an unprepared city, resulting in numerous alcohol-related arrests and property damage. In response to those problems the chamber of commerce established a task force to plan activities for spring break. The chamber of commerce reminded the city that spring break generates \$120 million in revenue for the city, and asked for one more chance to make it more manageable. The task force spent 11 months planning for spring break 1990, establishing committees to address issues such as hotel security, bars, parking, and wrist bands. The rules that were established were voluntary.

The task force also advocated reductions in the advertising of free drinks and happy hours. It adopted the "Party Smart" campaign of the Beer Drinkers of America Education Project, a responsible drinking education effort that includes the slogan "Party Hearty, But Party Smart."

Daytona Beach is a site for corporate marketing to what is viewed by many as an ideal target audience, mostly debt free and "ripe for the infusion of brand loyalty," according to Steve Gilreath, whose Expo America features a student-only exposition for 71 marketers, including General Motors and Warner Brothers. And while the beer marketers were conspicuously quiet in 1991, they were "[primarily] making sure their products are available at retail," said Gary Reynolds, president of Gary Reynolds and Associates, a marketing agency that creates showcase events (Spring break 1991).

Palm Springs, California

Students reported that spring break in Palm Springs would be "dead" in 1991 because of restrictions ranging from a ban on thong bikinis to restrictions on poolside drinking. The focal point for spring break action is Palm Canyon Drive, or The Strip, which is known for women clad in thong or string bikinis sitting on the back of motorcycles. One of the most controversial controls instituted in 1991 was a ban on thong bikinis through a new ordinance on public nudity.

Zelda's, located just off The Strip, is a popular bar that advertised spring break promotions in some campus newspapers. Zelda's was having a "Marlboro Party Nights" promotion, with banners and cigarette boxes hanging from the ceiling and a Marlboro prize center. An employee who was setting up the Marlboro promotion said that the alcoholic beverage industry was definitely maintaining a lower profile than usual this spring break. They did not provide a lot of promotion items, such as T-shirts and posters, as they did in previous years.

Confetti's, a bar and nightclub that advertised spring break promotional activities at some colleges, had more alcoholic beverage promotional materials, including a Budweiser "Welcome to Spring Break '91" banner, Budweiser posters, as well as Bud Paradise, Spring Break '91, and Miller Lite banners. Sam Ganoni, the bar manager, said this was the quietest spring break he could remember. Normally his bar is busy from opening until closing. In relation to alcohol promotions, he said "...the beverage industry was feeling a lot of pressure from the town to curb promotion and so they are hanging pretty low." Because of this, Confetti's did not have much to give away during spring break except a few posters of the Bud men and women of spring break. Ganoni also said that he was losing a lot of money this week as compared with prior spring breaks.

Because of town regulations regarding signs, including the prohibition of banners on building exteriors, as well as appeals to local retailers to moderate activities, Palm Springs did not have a highly visible alcohol industry presence. The exception was on-sale retail establishments, which promoted price discounts on flyers and handouts. For example, the Black Angus in Rancho Mirage boasted 12-ounce "ice teas" for party animals. The promotional materials in bars were limited primarily to banners and posters, with some novelty item giveaways. It was the general consensus of bar managers that the alcohol

industry had pulled back in 1991 in response to the concerns of the local community. In addition, Palm Springs has never had the level of spring break corporate marketing that the student expositions of Daytona Beach and Fort Lauderdale had.

Lake Havasu, Arizona

A number of San Diego State University students as well as students in Palm Springs reported that because of the restrictions in Palm Springs, the new "hot spot" for spring break is Lake Havasu on the Colorado River. "Lake Havasu or Bust" banners were displayed on some campers driving through Palm Canyon on the way to Arizona.

In Havasu City there were "Bud Paradise—Welcome to spring break" banners on the front of a bar at the entrance to the town, on a general grocery store, at a gas station, and outside the Taco Bell, as well as at other spots throughout the city.

Posted on the door of the hotel office was an advertisement for the "Lake Havasu Cruisin' Association—2nd Annual Easter Car Show" sponsored by Budweiser. The hotel desk clerk said there was a lot happening on the river and that in town the Budweiser team was going from bar to bar "giving away visors, posters, water bottles, T-shirts, and other things to people who were drinking Bud or Bud Light when the team came in the bars."

The action area during the day is on Lake Havasu, mainly in Copper Canyon, where students congregate in rented houseboats or cruise in speedboats. Most of the houseboats are crowded with students drinking from kegs of beer. One houseboat displayed a banner that reprinted the Anheuser-Busch logo, "Know When to Say When: Think Before You Drink." There were no other banners on the boats. The local Budweiser distributor said that at the start of spring break, he put a "Know When to Say When" banner on every houseboat as well as around town. The ratio of "Bud Paradise" banners to the "Know When to Say When" banners appeared to be about five to one.

Lake Havasu is gaining popularity as a spring break site. The area has not yet experienced the severe problems of Palm Springs or other sites in the Nation. It does not yet have the large crowds of Palm Springs nor does it have the same kinds of restrictions. The high visibility of Anheuser-Busch promotions at Lake Havasu contrasts with the relatively low level of activity in Palm Springs, suggesting a shift in marketing efforts to this emerging spring break destination.

Conclusion

Resort communities that host college students during spring break are confronted with the challenge of maintaining an atmosphere that is attractive to large numbers of young people yet maintains a level of control to reduce

problems that are disruptive to community life. The riots at Palm Springs and Fort Lauderdale prompted those communities to institute controls that have dramatically reduced problems. But they have also jeopardized the continuation of those cities as popular spring break destinations, resulting in lost revenues to the area and complaints by local businesses.

While the sheer size of the crowds descending on unprepared spring break destinations contributes to problems, it is the heavy drinking by students that is the main focus of problem-reduction strategies of most locations. Those strategies range from greater enforcement of existing laws governing drinking locations, such as Daytona Beach's no alcohol on the beach regulation, to the enactment of new regulations, such as Palm Springs' ordinance restricting poolside drinking to certain periods. In addition, cities have imposed restrictions on activities that had drinking as a focus, such as chug-a-lug contests and beer-sponsored concerts. Cities have requested that retailers discontinue marketing practices that encourage heavy drinking, such as happy hour discounts.

Cities that have developed task forces to address problems have attempted to engage in an open process. But the policies adopted are not always popular because they decrease revenues. Many businesses in resort communities depend on the large influx of students as a major source of their yearly income. As seen in Fort Lauderdale, and to a lesser extent in Palm Springs, cities that impose too many restrictions often lose students to other areas that are viewed as more liberal.

The pressure brought to bear against the alcohol industry has resulted in a moderation of some industry marketing tactics. Although the brewers and major distributors have ceased to actively promote spring break through special advertising in college papers and sponsorship of on-site activities, alcohol promotions at the retail level remain heavy. Bars and restaurants advertise in student newspapers, often touting reduced drink prices. Spring break is still associated with heavy drinking by college students.

The shift in student allegiance from one spring break site to another is often a result of the perception that "partying" is more tolerated at the new site. The differences noted in the level of alcohol promotions in Palm Springs and Lake Havasu illustrate student perceptions that Lake Havasu is an emerging "hot spot" spring break destination that has not yet experienced problems and subsequent control measures. Whether Lake Havasu's experience will mirror that of Daytona Beach as it became the new hot spot in Florida remains to be seen.

Comments on Observational Research

Timing is everything. This study was developed in spring 1990 and did not begin until late fall. That same year the FTC chair announced that an examination of college marketing practices was high on the agency's agenda, and in March 1991 the U.S. Surgeon General publicly requested that the brewers and

retailers "take a more responsible posture with regard to their marketing and promotion tactics during spring break" and received assurance from the Beer Institute that the brewers did not plan to take their tents, hats, umbrellas, and other promotional items to spring break in 1991. Thus, the marketing practices of the brewers were moderated at all sites observed. And the one night we spent in Lake Havasu was the first night off in 2 weeks for the Budweiser promotional team, so we did not get a chance to see them in action.

Youth isn't everything, but it's helpful. Having students participate in data collection provides greater access to information on marketing practices because they are the targets of that marketing. Throughout the project it was clear that many campus officials, including those working in prevention programs and faculty—especially faculty—are not very aware of alcohol industry activities directed at students. And youth is certainly the apotheosis of spring break.

Eternal vigilance is necessary. While the moderating of alcohol promotions by the brewers at spring break sites represents a public health victory, it does not necessarily represent a permanent state. Industry reforms in response to public criticism and the threat of regulatory measures often last only as long as the heat is on. In addition, the reforms have occurred primarily at the level of the producers. Distributors, such as the Lake Havasu Anheuser-Busch distributor, engage in their own promotional activities, and retailers continue with heavy promotional activities, usually related to price reductions or drink specials. While some spring break communities and campuses have instituted regulations directed at marketing practices, others rely on the voluntary compliance of the industry with requests for restraint.

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Using Community-Sponsored Research as a Basis for Social Action: A Case Study of Lysol Abuse in Edmonton, Alberta, Canada*

David Hewitt and Garry Vinje

The Nature and Characteristics of the Lysol Abuse Problem

A chronic problem that plagues many communities is the abuse of non-beverage alcohol products (NBAs). NBAs are household and industrial products that are consumed as a beverage because of their alcohol content. Disinfectants, personal hygiene products, and solvents, to name only a few, are among the goods that are abused in this fashion. Factors such as cost and availability are frequently cited as reasons for their use.

In western Canada, one NBA that has been the focus of particular concern is Lysol brand aerosol disinfectant. Lysol is marketed as a household disinfectant, but has become widely used as a substitute for conventional beverage alcohol by chronic alcoholics. Although several different types of disinfectant are marketed under the Lysol label, only the regular scent brand has been the subject of widespread concern.

Lysol's popularity as a substitute for conventional beverage alcohol is not hard to understand. The principal ingredient of Lysol is alcohol—the product in Canada is approximately 67 percent ethyl alcohol. Most of the remaining ingredients are inert substances except for minute concentrations of phenols.

For over a decade, concerns about the abuse of Lysol have been expressed by various groups in western Canada. These concerns have typically resulted in letters to the manufacturer requesting reformulation of the product and campaigns to alert merchants to the problem.

None of these efforts has been effective in resolving the situation. The manufacturer has consistently responded that they have had difficulties in formulating a new product that is equally effective yet safe to use. For their part, some merchants have resorted to storing Lysol behind the counter, but this action has not affected availability significantly.

Rekindled Interest in Edmonton's Lysol Problem

In late 1989 concern over Lysol abuse resurfaced in Edmonton when the director of an inner-city housing agency drew attention to the problem through

*This paper was accepted for presentation at the symposium and is included in these proceedings even though the authors could not attend.

a letter he sent to Alberta's minister of health. In response to his concern, a meeting was arranged between several inner-city organizations and the Provincial government's addiction agency, the Alberta Alcohol and Drug Abuse Commission (AADAC). It was agreed at this meeting that while there was a great deal of anecdotal evidence concerning the Lysol abuse problem, little empirical information was available. Without this factual information as background, it was recognized that it would be difficult to develop a strategy to combat the problem and mobilize the necessary community resources to carry it through.

The plan of action that was developed as a result of this discussion is undoubtedly similar to the strategies devised by other communities as they attempt to confront their own unique social problems. The Edmonton coalition recognized that before meaningful corrective action could take place, they would have to arrive at an understanding of the magnitude and nature of the Lysol problem. To do this, the groups would first have to undertake a study of the problem.

A Learning Experience for Community Agencies

For the community agencies that did eventually participate, the Lysol study marked the first time that most of them had taken part in a research project that was to serve as a basis for community action.

During the planning and implementation of the study and the subsequent dissemination of the results, a number of issues and problems arose that the agencies had to overcome. These experiences, described below, offer useful insight into how community-based, action-oriented research should be undertaken. Many of the lessons will be relevant to others who are considering undertaking their own community-based research.

Lessons From the Edmonton Experience

The principal lessons from the Lysol study can be summarized as follows:

1. A community-based research project needs an initial organizer to draw attention to the problem and constructively orchestrate the activities of the community agencies.

In many cases, an agency or person is responsible for initially focusing awareness on a community problem. For any long-term action to take place, this person(s) must be able to move from simply drawing attention to the problem to actually nurturing corrective action.

To accomplish this, the person or agency needs to do more than simply point a finger of blame. Instead, they must be able to rationally discuss the problem while conveying a sense to others of what needs to be done. The qualities that the organizer may find helpful in doing this task include good organizational

skills, a solid commitment to addressing social problems, a thorough knowledge of the issue in question, and the ability to articulate concerns clearly.

In the case of the Edmonton Lysol situation, the problem was initially identified by the director of a low-income housing agency. Through his years of working in the inner city, this person had developed a thorough understanding of the problems of inner-city residents, including the difficulties associated with Lysol abuse. The person was also well known and respected by his colleagues. All these factors worked in his favor when he began asking others for help in addressing the problem.

2. Any community research project must begin with a wide base of support within the community.

Every community agency that is potentially affected by the problem should be approached for its cooperation in undertaking the research. The greater the base of support within the community, the easier it will be to get the study under way and implement the recommendations that stem from the findings. In this regard, it is important from the outset to try not to alienate anyone. Even those who are viewed as being responsible for a problem could be useful in the future.

In the Edmonton study, the concern about Lysol abuse was initially confined to a small group of agencies. However, virtually all inner-city agencies impacted by the problem were contacted for their ideas during the course of the study. Also, the study facilitated closer contact between the community and the manufacturer regarding the problem.

3. It is better if the research skills needed to undertake the study can be found within the community in question.

Although many community agencies may feel that they do not have the ability to undertake major research projects themselves, they are even less likely to have the financial wherewithal to pay professional outside research consultants. Therefore, it is advantageous for community agencies to do as much of the work as possible themselves. Many communities will be surprised at the amount of research expertise available to them in their own community. By using local expertise, the data-gathering process will not only be less costly, but will also be faster and less complicated.

For the agencies involved in the Lysol project, all the resources needed to complete the study were found within the participating community agencies. Although AADAC did coordinate the overall project, other agencies were expected to, and did, contribute in their own way.

4. Community action research has a number of unique characteristics that distinguish it from more conventional approaches to research.

Conducting community research presents a wide range of issues and complications that do not appear in more conventional academic or controlled studies. Those contemplating such research should be aware of the following attributes:

a) The researcher must be able to find a balance between what he or she would like to do with what can realistically be accomplished.

Typically, when working with or for community groups, financial and manpower resources are in short supply. Also, the time lines can be quite short and are usually outside the researcher's control. These factors will likely mean that the researcher will not be able to be as thorough or comprehensive as he or she would otherwise like to be. Accordingly, he or she must compromise between what would be the ideal and what is absolutely essential. To be of assistance, the community agencies must be clear about the purpose of the research and what their precise needs are.

For AADAC, the opportunity to examine the abuse of Lysol opened a number of exciting possibilities. However, it was soon realized that the costs of the project and the need to produce results quickly placed major constraints on the study. In the end, the study was limited geographically to Edmonton's inner city, the actual data collection period was shortened to 6 weeks, and the amount of data collected was confined to but a few key variables.

b) The researchers must recognize that they will not have complete control over the project and that the ability to work cooperatively within a group is essential.

The collaboration among agencies that undertake community research can be quite loose. It thus may be difficult for the researcher to find precise direction or even to determine who is in charge. Notwithstanding this scenario, the researcher will have to be able to accommodate the suggestions of the participating agencies because many will have their own views about what is important. The ability to listen attentively in what may be a very unstructured context is an important quality for the researcher to possess.

For various reasons, the agencies that participated in the Lysol study never formed a formal committee during the study. AADAC was thus left largely on its own to ensure that participating agencies were kept informed of developments and allowed to contribute to the project.

c) Ownership of the project must rest with the community groups, not with the researcher.

The study must always be viewed by the researcher as the property of the community groups that instigated the research. If this sense of community ownership is not maintained, the researcher runs the risk of losing community interest and involvement in the project. To avoid this problem, the researcher should never assume control of the project, but rather should accept direction

from the community representatives. Also, the final decision as to how the results will be used should rest with the community.

When undertaking the Lysol study, AADAC recognized how important the issue was to the participating inner-city agencies. These agencies saw the effects of Lysol abuse daily, and they had originally asked that something be done. While AADAC had a responsibility to offer advice and suggestions, the commission did not make any decisions without input from the other groups. The plan on how to disseminate the results was left completely to the community.

d) An innovative, nontraditional approach to the research is necessary.

Most social problems are complex, involving a significant number of variables. It is usually impossible to study these problems without considering their context. This need to consider the context makes it difficult to employ a traditional experimental approach with its emphasis on rigorous control of variables.

Because of this difficulty, a less structured approach to community-based research is needed. For example, it may be necessary to use multiple measures, and not rely on one instrument. Also, specialized techniques, such as the use of unobtrusive and indirect measures, may be employed more extensively than with conventional research. Finally, the researcher may have to settle for incomplete data and may have to make significant inferences based on the limited information available.

The research design employed to collect data in the Edmonton Lysol study illustrates the use of an innovative approach to study a community problem. It was clear from the outset that a variety of measures would be necessary since no single instrument or agency was capable of gathering all of the information that was required. Ultimately, data were gathered through the use of direct measures, such as the direct surveying of Lysol users and the directors of local helping agencies, as well as through the use of indirect measures, such as counting discarded Lysol cans and checking stores to see how the product was displayed. By combining the results of these various indicators, a composite picture of the situation was formed. The types of measures that were chosen reflected the constraints imposed on the project.

e) Careful thought must be given to how the results will be disseminated.

Simply undertaking a study and producing a report is not sufficient to institute change. Reports and published articles frequently go unnoticed, particularly by those who are in a position to change things. Thus a communication strategy should be in place from the outset to ensure the findings are disseminated in a thorough yet timely fashion.

The communication plan should cover a number of areas. To begin with, a

spokesperson should be identified who is capable of explaining the problem and possible solutions in simple terms. The release of the report should be timed as much as possible to maximize its exposure. The findings should be presented in a simple, straightforward manner, with complicated statistical analysis kept to a minimum. Finally, recommendations for future action must be realistic. The likelihood of a recommendation being acted on is greatly increased if it is easy to implement.

Results of the Lysol study were selectively released to only those media outlets that expressed a longstanding and active interest in inner-city social issues. As planned, these outlets gave the story extensive coverage, and it was soon picked up by other outlets. Ultimately, the story received national coverage in print and on television and radio.

A spokesperson from one of the community agencies was chosen as the media contact. This person, who had extensive knowledge about the issue, became the main contact for the media.

The findings were kept simple. The number most often quoted by the research team was the estimate of the number of Lysol abusers in the inner city, which was calculated to be in the vicinity of 200 to 500. Cautions and disclaimers about the validity of the estimate, although noted in the report, were not emphasized to the media.

Finally, reasonable recommendations were put forth by the community agencies involved in the project. These recommendations called for the provision of additional treatment services in the inner city, changes to Provincial legislation to better control Lysol, and more discussions with the manufacturer concerning reformulating the product. None of the recommendations could be interpreted as being particularly radical.

A Successful Ending

The success of any community action research project is ultimately measured in terms of the effect it has on the community. In the case of Edmonton's Lysol study, the effect has been extremely positive in that there has been a notable reduction in the abuse of the disinfectant.

This reduction can be attributed to a number of developments that immediately followed the release of the report. In particular, the Provincial government revised the legislation that pertained to NBAs. With these amendments it became an offense under Alberta's Public Health Act for merchants to sell disinfectants such as Lysol if they should have known the product was going to be abused.

Coincidentally, the Edmonton City police began a crackdown of merchants in the inner city who were selling Lysol. The crackdown resulted in a number of convictions that have, in turn, encouraged merchants to be more responsible in retailing the product.

In addition, meetings were arranged between the manufacturer and community agencies to discuss the situation. Although a reformulated product is not on the immediate horizon, these discussions have proved useful, and the manufacturer has supported various prevention activities in the inner city such as the production of warning posters.

Finally, the study has served as a stimulus for community agencies to meet regularly to discuss the problem. These ongoing discussions have maintained community interest in responding to the problem.

Lysol abuse, and the abuse of other NBAs, remains a problem in Edmonton. But through the actions of local community agencies and the research they have sponsored, the problem has been reduced significantly. This is an example of how community-based action research can address an important social issue.

Symposium Plenary Discussion

In response to a question from Tim Stockwell, Eckart Köhlhorn explained how observations were made in the Swedish study to determine how many of the Midsummer Eve celebrants were drunk. He said it was not possible to be sure whether subjects actually were drunk or only appeared to be drunk, but observers tried to be systematic, using such tests as whether persons moved directly from one place to another or moved erratically. Even with its shortcomings, he said, these direct observations can provide better data than what comes from arrest reports by police.

Christina Nereson asked Barbara Ryan about the impact expected from publication of her report. Ryan said the report included policy recommendations for communities to respond to student drinking problems. An important one, she said, is monitoring the promotional activities of alcoholic beverage companies. In the United States, money that the companies previously spent on mass media advertising now appears to be shifting into sponsorship of events that attract students.

Louis Gliksman asked how recommendations could be applied to a "community" in cases where a community of students is not defined by geographic boundaries but is defined more by a cultural norm, such as the obligation students might feel to drink even when they are not on a campus. Ryan said the traditional community approach to undesirable student drinking is through law enforcement and regulations on public drinking, but a more fruitful approach would be an environmental one. Since marketing messages contribute to student expectations, intoxication might be reduced if there were fewer reduced-price specials and other promotions that are seen as an invitation to heavy consumption. Ryan said many retailers are reluctant to support regulatory

measures on drinking for fear they will lose the spring break student crowds that benefit business in the community.

Paul Duignan asked about the source of funding for Ryan's study. She said the spring break study was part of a broader project funded by the National Highway Traffic Safety Administration and OSAP. Duignan also noted that spring breaks were binge occasions for students, while breweries conduct year-round campaigns aimed at encouraging use of their products by students. Ryan agreed that heavy drinking on special occasions on or off campus was influenced by the year-round promotional activities of the industry.

Friedner Wittman commented that drawing attention to the problems created by alcohol at large-scale events was an important function of a community prevention program. "There's been a major shift in California in the last several years to remove alcohol from such events," he said. "In the past there had been an uncritical acceptance of the fact that there would be a lot of drinking and drinking-related problems at those events." Ryan's descriptive study of spring break activities serves as an example of how simple observations can have an impact by drawing attention to problems that people were taking for granted.

Jeff Hunt pointed out that 20 or 30 years ago some of the researchers at this conference might have been involved in spring break activities that they now may be deploring. Ryan pointed out that in the intervening years there have been major changes in the marketing strategies of beverage companies. Advertising is now more in the lifestyle vein, and events like spring break are more commercialized. One can speculate whether heavy drinking would be as evident in today's student group had these changes not occurred.

Ryan asked Knutsson whether the efforts to control drinking at Borgholm on Midsummer Eve had been unpopular with local citizens because of the threat of economic loss to the town. Knutson said the town as a whole did not seem worried, but restaurant and bar operators and others directly involved in the tourist business were worried about the impact of the program. Ryan said that some businessmen in Palm Springs were highly critical of policies that put a damper on the number of students coming for spring break.

Naturalistic and Controlled Studies: Commentary and Reflections on the Day

Jussi Simpura

These introductory remarks are aimed to further confuse our understanding of community prevention by bringing a European perspective to the discussion. The structure of my remarks is a lengthy introduction, and then very short remarks on the papers. I have listed a few questions that came to mind yesterday and today. I don't necessarily answer those questions, I don't necessarily touch them at all, but maybe they will serve for further discussion.

Are there communities outside the English-speaking world?

Where are the limits of community action in terms of economics, politics, and geography?

How do we study large-scale naturalistic settings?

How do we transfer models to countries with different political or administrative structures?

What is *not* community action?

My impression is that in countries outside the present European Community (EC) there will be increasing opportunities for naturalistic experiments that study community action and community reaction to alcohol and other drug use. The advancing economic and political integration that will alter borders and facilitate visits and trade will force many countries to reformulate their alcohol and drug control policies. Actually, yesterday we heard an interesting perspective on the effects of political changes on alcohol in Poland. I myself have been involved in a project with Jacek and many other people on the perception of social problems, including alcohol and other drug problems, around the Baltic Sea, including in the republics that recently gained independence. That context really shows what can happen to our views of the nature of social problems and alcohol and other drug problems.

But at the same time these political and economic changes are taking place interest in controlled community actions on alcohol prevention will increase because the centralized national operations will lose their jurisdictional space and extensive multinational operations will be increasingly difficult to control in the very variable conglomeration of European countries. So my forecast—this is almost a market forecast—will be that the demand for well-documented community action experience will be on the rise in Europe, and methodological expertise will be highly valued. The papers from the morning session today might serve well for a European audience in coming years.

The term community, to my mind, entered into the European discussion of alcohol and other drug problems with the famous Community Response Study on Scotland, Zambia, and Mexico. The study led to quite a number of European successors. Poland's experience was discussed yesterday. Another stream of community action is the WHO activity around the Health for All by the Year 2000 program and the Healthy Cities program, which to my knowledge was actually started in Europe. I think the Healthy Cities program does not necessarily focus on alcohol and other drugs in general. What we heard about Oxford yesterday is an exception within this program and is perhaps also an exception in Britain.

The WHO regional office for Europe is currently preparing a new alcohol-related program called Alcohol Action Plan (AAP). Although the final proposal for that program is not available yet, it will be a surprise if the AAP does not build on the non-European experience in community action.

In Europe, with its variable cultural and political traditions, community action is a loose and general concept, referring to local and small-scale operations. It is perhaps more politically acceptable than broader, stricter, and more uniform multinational operations. On the other hand, this looseness may become counterproductive when almost anything can be called community action.

In Europe it may be correct to claim that the dominant model for action on social and health problems is a noncommunity one and often a nonmedical one, and this concerns alcohol and other drug uses in particular. In drug prevention, nationwide and even continentwide, police operations are given the most emphasis. In the prevention of alcohol problems most European countries have taken few concrete steps, with the notable exception of four of the five Nordic countries. Recently, of course, France has introduced a kind of new European thinking on alcohol prevention with its advertisement bans and other proposed activities.

Notably, the European communities have not created any common health policies, and, of course, there is no common line in the prevention of alcohol problems. Now it is possible that a historical turn can be expected here because the EC summit meeting in the Netherlands in December 1991 decided, among more important things, that health policy issues will be included in the agenda of coming EC meetings. So far health policy issues have been discussed only within the narrow scope of industrial relations for protection of employees at work.

The Community with a capital C also pays attention to communities with smaller initials. To cite the documents of the Maastricht conference, communities "shall contribute toward ensuring a high level of human health protection by encouraging cooperation between Member States and, if necessary, lending support to their action. Community action shall be directed

toward the prevention of diseases, in particular the major health scourges, by promoting research into their causes and transmission, as well as health information and education."¹

Now you can see or hear the confusion in the use of the term community in Europe. The declaration refers to action that will be taken by the EC, but, on the other hand, some of the ongoing activities within the health and social sector of the EC seem to focus on local communities as key instruments or vehicles. There are a number of EC action programs "favoring and protecting certain categories of people," including programs in favor of elderly people and action for handicapped people and certain disadvantaged groups, and also programs for promoting the integration of the least privileged groups. So I don't know actually how those community actions, as they are called in the official EC documents, conform to the idea of community action as discussed at this conference.²

Besides the EC activities there is another line of development that may lead to increased interest in community action on health and social policy. And this line comes from the critique of the welfare state interventions or state interventions in general. This critiquing has been very strongly felt in Germany since the 1970s and later also in many other countries. It raises the question of the legitimization of centralized state interventions into everyday life. This may sound odd to Americans, but is quite a common topic of discussion in Europe. This critique has also led to a number of proposals for changing the existing structures of the welfare states. Among them is one idea to reform the welfare systems "from below" by developing "local anti-crisis strategies by means of engaging new and old social movements as a counterpart of neoconservative reforms."³

In this perspective, the present economic integration of Europe represents mostly neoconservative ideas with emphasis on economic "freedoms," as they call them, and requirements of health and welfare policies. To oppose those tendencies, local and small-scale initiatives at the grassroots level should join together, often with the idea of community identity, either a local one or one based on like-mindedness. I would say that in Europe I haven't very often found such thinking about community as is common over here in America. It may be that the whole idea of community action is strange or unfamiliar for national reasons to many European discussants, which may be one reason why there are not more Europeans present here.

Indeed, the variability of political or administrative structures should be accounted for when we consider the feasibility of community action in preventive health and social policies. So one would expect that the community action approach is most feasible in such countries where the existing welfare system is loose enough to allow the sometimes unusual operations required by this approach. On the other hand, some degree of organization of civil interests

is required as a framework for the activities. At this conference one might be surprised to see that as many as three papers today come from Sweden, which to my mind is the country with the most extensive State interventionist health and social welfare system in the Western industrialized world. I wonder whether this will be taken as an indication of a peaked crisis in the Swedish welfare state or only as a sign of the problems in continuing the strict alcohol control policies in that country.

Examples of increasing interest in community action on alcohol and other drugs in Europe, outside of government control activities, can already be found. Denmark's minister of health recently proposed new alcohol legislation in which local communities and county administration should be given primary responsibility for prevention work. It may be merely a coincidence that the Danish alcohol research community has worked for a long time on the idea of studying "alcohol consumption consciousness"—an approach that emphasizes the importance of values and expectations created during micro-level communication in local communities. This kind of value structure would work as a protective shield against drinking problems. Therefore, the original thinking of Denmark where alcohol policies are concerned becomes strongly supportive of this research.

That ends my introduction; I will now comment on the papers. First, I would like to challenge the idea of using the title "special settings" on these papers on needs assessments or natural experiments. Rather, I would say these are normal, standard situations in the real world. What is special is the experience of these methodologically very advanced community action experiments and trials that you have so many of here in America.

An interesting problem is meeting the methodological requirements of evaluation of the supposedly free movement of community action at trial sites. This aspect was mentioned in the paper presented by Alex Wagenaar in the morning and was also exemplified in the paper by Louis Gliksman yesterday. As Alex and his colleague reported, community organization is most effective when it is not rigidly controlled from above, but at the same time local autonomy raises the possibility of treatment heterogeneity in the context of an experimental design. Alex believes that in practice this paradox is more apparent than real. Maybe the paradox can be controlled for somehow in projects as extensive as the one he describes. In smaller scale attempts I would guess that the pursuit of local freedom may be a more real concern.

In the two Swedish papers from the morning session we have examples of applying a community approach in a society totally penetrated by public intervention, protection, and services. The question arises on the nature of Kungsholmen and Kirseberg as communities. Both are located within large cities and, as I understand it, it is hard to tell whether these are local communities or not. Methodologically, the goals in these Swedish papers are less

ambitious than those in certain American and Canadian experiments. The lack of control communities and the limited possibilities of doing long-range, time-series experiments should be mentioned here. But, on the other hand, the Swedish welfare system provides the researchers with a wealth of information at the community level, which can make cross-sectional data useful.

The Kirseberg paper raises an interesting question about the individual's integration into the community as a predictor of alcohol problems. It appears that the ties within the community are less important than the individual's powerlessness in the face of everyday life's requirements. If this is true, I think it would have deep implications for community action programs.

The two Canadian papers under the category "needs assessment" seem actually to be quite different. The first one about college students does not contain much material on needs assessment, to my mind, and it is quite an ordinary campaign. The authors considered the limitation of their research setting fairly exhaustively. The other paper focuses specifically on methodological needs assessments in workplaces. The importance of any changes in a worker's status and the commitment of management appear to be crucial. The question of how and why a needs assessment should be conducted is discussed in this paper to some extent, with the emphasis on providing concrete information instead of abstract models.

Last, the two papers on naturalistic experiments from Sweden and the United States fascinate the reader with the uniqueness of the events described. For a researcher, however, the study of naturalistic experiments on community action is problematic. Such events cannot be studied in any rigorous experimental setting so they must be studied afterward....I hope we can discuss to some extent the possibilities of developing a better methodology for studying naturalistic event settings for community action.

In general, I hope that for European readers in particular lots of good books and articles that pertain to methodological problems of community action and community trials will soon be available. I've noticed in some other papers an indication that such books are coming already. The time is right for everyone interested in contacting the markets in Europe to publish, not to perish.

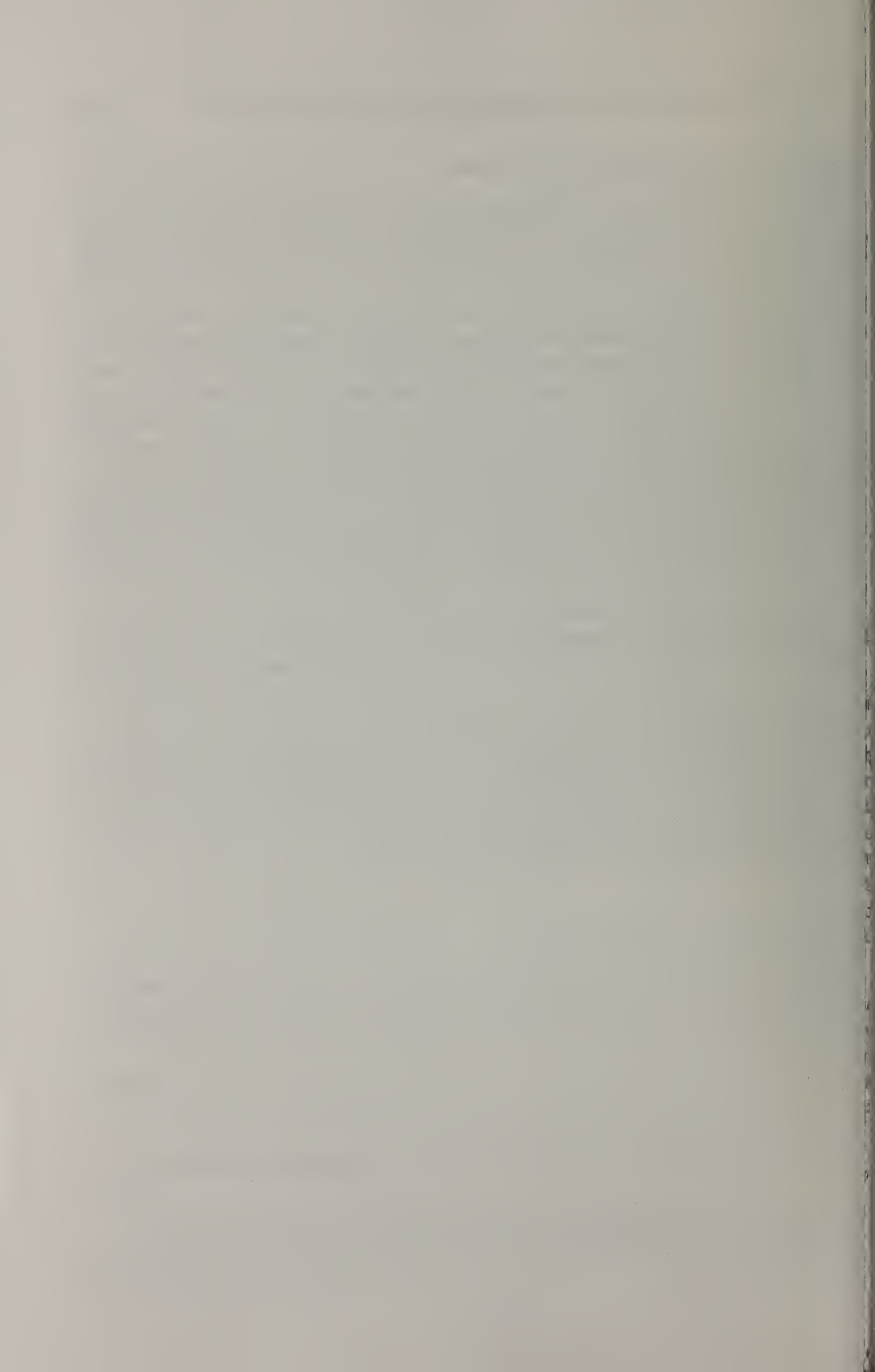
Notes

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Symposium Plenary Discussion

A questioner asked about the apparent lack of interest in raising the drinking age in Europe, noting that in Sweden there is even discussion of lowering the drinking age from 20 to 18. Jacek Moskalewicz said he believed that directing attention to drinking by youth might be a form of scapegoating by the community. Blaming scapegoats can take attention away from issues in the community that are difficult to approach politically. Geoffrey Hunt observed that tyranny may hinge on the nature of community representation—that community representatives tend to be self-appointed and may not really represent the grassroots they purport to. Anders Romelsjö commented that the legal drinking age may be less important than what is actually happening—the rates of drinking by young people. In Sweden, he said, alcohol policy debates are dealing with issues considered to be more important, such as taxes and pricing and abolishing the State monopoly. However, it was also pointed out that the drinking-age issue might go on the national agenda in countries like Sweden as a consequence of entry into the EC.

Shireen Mathrani commented that the actual drinking age in India seems to be associated with the age of marriage, which is well below age 21. Jim Anderson added that even in countries where the legal drinking age is relatively high, young people still have access to alcohol. Tim Stockwell commented that reliance on a legal drinking age as a prevention tool could lead to setting the age at 25 or 30 in the interest of harm reduction. He said he believes there are more fruitful enforcement policies to be pursued. Finally, Ryan pointed out that the 21-year-old drinking age creates problems at colleges because it splits the campus population into two groups and can lead to other problems because of the context it creates for illegal student drinking.



CHAPTER 5

Broad-Based Programs: The “Fit” with Local Grassroots Initiatives

How Well Do National Programs Take Account of Local Situations?

Case Studies of Comprehensive Community Planning To Address Alcohol and Other Drug Issues: The Evaluation of the Fighting Back Initiative

Kathryn Stewart and Michael Klitzner

Introduction

It has become an article of faith that communities must mount comprehensive and coordinated efforts if they are to make progress in their efforts to combat alcohol and other drug problems. Federal and private foundation grants as well as conventional wisdom now encourage this approach in communities across the country. Certainly, we have reason to be frustrated with single-focus programs operating in isolation. But how realistic are our expectations that communities can successfully implement such comprehensive programs? How do the particular characteristics of the community affect their implementation? Pacific Institute has the opportunity to answer these and other questions in its evaluation of the Fighting Back Initiative funded by the Robert Wood Johnson Foundation.

In 1989 the Robert Wood Johnson Foundation awarded grants to 15 communities throughout the United States to carry out 2 years of planning for the Fighting Back Initiative. The initiative is designed to support intensive, communitywide activities to reduce the demand for illicit drugs and alcohol. During the planning, the communities were directed to accomplish the following:

- Assess the nature and scope of alcohol and other drug problems in the community.
- Assess current community resources relative to the identified problems.

- Develop 5-year work plans to implement comprehensive, coordinated strategies in the areas of public awareness, prevention, intervention, treatment, and aftercare.

The communities included in Fighting Back are ethnically, geographically, and politically quite diverse. The evaluation thus provides an ideal opportunity to explore how community planning operates under a wide variety of different circumstances. The communities have just completed the planning process and several will receive continuation funding to implement the full Fighting Back Initiative.

At this point, the evaluation of Fighting Back can provide only preliminary hints of the apparent success of the planning efforts. An outcome evaluation of the initiative will take place during the next 5 years. However, the evaluation of the planning process allows us to assess how well communities can organize and plan such comprehensive initiatives and also to examine the characteristics of the communities and of the planning process that seem to facilitate or impede progress.

Methods

The evaluation findings discussed here are based on preliminary, qualitative analyses of two rounds of site visit data gathered from the 15 Fighting Back sites during the period October 1990 to February 1991, and July through September 1991. A full report on the evaluation of the planning process, including analysis of all data collected, will be produced in 1992.

Five categories of respondents representing a total of approximately 30 individuals per site were interviewed during the first round of site visits. These categories included:

- Fighting Back staff.
- Chairs and members of the various Fighting Back planning bodies.
- Individuals invited to participate in Fighting Back who declined.
- Community officials, including the mayor, alcohol and other drug agency director, school superintendent, police chief, alcohol beverage control director, a local judge, the director of human services, the director of health services, and the director of housing.
- Communitywide informants, including a local historian and a political reporter.

During the second round of site visits, Fighting Back staff and key volunteers were interviewed. In addition, in some sites other key community informants who had been identified during the first visit were interviewed. The emphasis in the selection of these last informants was on individuals who were

known to have conflicts with Fighting Back or alternative views about the initiative.

The interviews during both site visits were semistructured and varied in length between 1 and 5 hours. When interviews could not be scheduled during the site visit or could not be completed during the available time, all or part of the interviews were conducted by telephone.

Findings

The Fighting Back Initiative is highly ambitious and presents major challenges to all the communities. Different circumstances in different sites led to greater or lesser progress during the planning process. Before turning to the specific factors that seem to have facilitated or impeded progress, we believe it is instructive to highlight some of the key successes of Fighting Back.

First, Fighting Back has generated a great deal of activity in the sites with what are, on a per site basis, relatively small grants. An extraordinarily high level of staff and volunteer activity and support was observed in all the sites. In addition, all sites expressed the intention to continue with Fighting Back regardless of implementation funding.

Second, Fighting Back has been successful in bringing together agencies and groups that had not previously interacted. In several sites, agency representatives reported that they were now communicating with other agencies about which they had previously known little or nothing. This increased communication within the system is, in itself, evidence of a positive system impact of Fighting Back, one that is of considerable importance independent of other outcomes. Fighting Back has also stimulated cooperation where little existed. In one multiracial site, two groups that were historically at odds over a number of issues both reported that Fighting Back represented the first time in memory that the groups had worked cooperatively and effectively to solve problems. By the site's own standards, this is a significant accomplishment.

Third, the Fighting Back staff and volunteers are uniformly of high quality in terms of education, experience, and professionalism. In addition, key volunteers and consultants include prominent politicians and business leaders, as well as a number of individuals who have national reputations in substance abuse and related fields.

Finally, the evaluators' judgment is that positive change will occur in most sites, even if the overall vision of a coordinated, communitywide system of responses to substance abuse is not fully realized.

With these overall successes in mind, we turn to a discussion of some of the specific variables that seem to have been most powerful in affecting the progress made at the sites.¹ The variables we will discuss here include social context and the assumptions underlying the planning process.

Social Context

Two related social context issues emerged from the site visits: community ownership of the problem and inclusion/exclusion of ethnic groups.

Community ownership of the problem

Substance abuse, and alcohol abuse in particular, is found in all age groups, in all racial groups, and in all social and economic strata. Yet, in some sites, there is a perception that the problem is primarily or exclusively found in a specific target population. In response to the question of what segments of the population of (the target community) have the most serious alcohol and other drug problems, most respondents dutifully replied that all segments of the population have problems. But many respondents, especially members of disadvantaged groups, reported that middle-class citizens (who make up the majority of Fighting Back participants and community officials) focused their attention on the alcohol and other drug problems of the poor and disenfranchised. These respondents were also quick to point out, however, that drug busts and sting operations in the inner city are as likely to involve suburbanites who come to the inner city to purchase drugs as they are to involve inner-city residents.

The uneven attention to the alcohol and other drug problems of various community groups and the tendency among Fighting Back participants to view the problem as "theirs, not ours" may present barriers to mobilizing the entire community. Equally important, these attitudes further complicate issues of inclusion and exclusion of affected populations.

Inclusion/exclusion

All the Fighting Back sites are multiethnic, and some have experienced significant racial tensions in the past (i.e., race riots). Even among those sites where racial tensions are more subtle, sites are experiencing difficulties related to the inclusion or exclusion of key ethnic groups in the planning process. A typical problem in terms of inclusion is that the lead agency is seen as coming from another world—usually the white, middle-class world. Even when the lead agency is run by ethnic or racial groups, there may still be suspicion that the agency is "too establishment." One underlying difficulty here is that in order to successfully compete for a grant of this magnitude, the lead agency must be relatively stable and well established.

In most sites, concerned citizens of all ethnic and racial groups are invited to participate in Fighting Back. Some sites have made concerted efforts to involve citizens and solicit their input by holding a series of community forums in different neighborhoods. In other sites, however, average citizens, especially those whose participation has been hampered by language or cultural barriers, have not felt fully included in the process.

One particularly important aspect of this problem has been attempts by sites to include ethnic populations by inviting a few representatives of relevant groups to serve on planning bodies. Not surprisingly, the African-American or Hispanic or Asian communities do not necessarily believe that their diverse views can effectively be represented in this way any more than the White community would believe that one or two people who happen to be White could speak for the "White community" as a whole.

Assumptions Underlying the Planning Process

Two important sets of assumptions were revealed in the site visits: (1) assumptions concerning the alcohol and other drugs problem and (2) assumptions concerning how community planning is accomplished.

Assumptions concerning the problem

It seemed likely that the underlying assumptions of participants in Fighting Back about alcohol and other drug problems would affect the nature of the plans developed. Therefore, three sets of questions concerning assumptions were asked of all respondents. These questions concerned the best way to conceptualize alcohol and other drug problems, the causes of alcohol and other drug problems, and the best ways to respond to alcohol and other drug problems.

Respondents overwhelmingly endorsed a disease model of alcohol and other drug abuse, reflecting an individual-level conceptualization of problems associated with abuse. There was equal unanimity as to the causes of alcohol and other drug problems, which were viewed as social in nature. Poverty, disenfranchisement, and deterioration of the family were commonly cited. Peer pressure was a common explanation for abuse by young people, reflecting prevailing cultural beliefs.

Opinions concerning the solution varied widely. Some respondents politely restated the Fighting Back rhetoric or simply stated that Fighting Back was the solution. Among others, education and community awareness, often coupled with a reduction of community denial, were common solutions. In communities where substance abuse was clearly seen as a symptom of other problems, many respondents cited the need to address root causes.

There is not always a strong logical connection among the commonly stated nature, causes, and solutions to substance abuse as reported by respondents. The single most common set of responses might be restated as substance abuse is a disease, caused by social ills, that is best addressed through education. These responses reflect conventional wisdom but do not take into account available research knowledge. In many cases, this conventional wisdom seems to be reflected in the implementation plans that do not always include the full range of strategies found to be effective in combating alcohol and other drug problems.

Assumptions concerning community planning

The planning structures and processes designed for Fighting Back seem to be based on certain assumptions about planning. One of these assumptions is that the collectivity will make the right choices—that is, the mere fact that a planning body (as opposed to a few individuals) is doing the planning will ensure a rational implementation plan. Of course, involving many thinkers is an important part of any creative process. However, in the absence of substantive expertise on or input to the planning body, it is unclear how an effective plan will be developed. Unfortunately, during the planning process, sites were still competing for implementation funding and it was not considered appropriate to provide site-specific technical assistance. Often there is little substance abuse information flowing into the sites and limited expertise among program decisionmakers. Thus, it is not surprising that the plans developed by the collective process may be consensual but often do not reflect the current knowledge base in the substance abuse field.

A second widely held assumption is that community representation on the task force will ensure community acceptance of the Fighting Back plan. This assumption must be considered in light of several of the findings discussed thus far. As noted, it is often difficult to determine who represents various segments of the community. Clearly, for example, the inclusion of ethnic and racial groups on the planning bodies does not ensure that these individuals are seen as representative by the populations from which they are drawn. As also discussed, residents in some communities are suspicious of Fighting Back, the lead agency, or the foundation. That these residents are “represented” on the planning bodies may be cold comfort to some. Thus, depending on how fragmented the community is and how effective the planning process has been in obtaining input and endorsement, some segments of the community may feel disenfranchised from the process or may disagree with the plans and priorities adopted.

Conclusion

In many ways the planning structure and process outlined for Fighting Back seem to have worked well in moving the sites toward a comprehensive and intensive initiative. Fighting Back has stimulated a high level of activity and interest in all the sites. Staff and community participants are of high quality, and there are positive signs of increased interagency communication and community cooperation. However, the structure and process are not sufficient in and of themselves. The particular characteristics and barriers at the individual sites require additional guidance and effort to enable them to fully involve and gain endorsement from diverse community elements. In some sites, even after the formal planning process has been completed, groundwork is still being laid for the community consensus and collective will necessary to plan and implement Fighting Back. In addition, sites need intensive technical

assistance regarding state-of-the-art technology in demand reduction relevant to the drug problems at each site. Overall, the initiative has a great deal of promise. With additional effort and input in key areas, the full potential of Fighting Back can be realized.

Note

1. Variables discussed here represent only a small portion of those explored in the evaluation. We have selected for discussion here those variables that seem most relevant to similar efforts in other communities.

The Unintended Consequences of Planned Social Change: The Case of OSAP's Community Partnership Program in a Northern California County

Geoffrey P. Hunt and Ron Roizen

This paper briefly recounts an old story in organizational behavior—namely, the story of how a social program premised on a particular set of philosophical commitments and aimed at achieving a particular set of social goals nevertheless, in due course, found itself faced with a number of unanticipated and unintended organizational strains and dilemmas. Our account offers no antidotes for this, but it does include some positive and—we hope—useful observations. At a minimum, knowing in advance of the strains and dilemmas we describe, we believe, is better than not knowing of them. An understanding of these strains and dilemmas can also broaden and enrich the deliberations of those persons involved in trying to surmount them. This is not to say that the participants themselves do not discuss and attempt to resolve these strains and dilemmas as the problems come up in the project's evolution; they do. Strains and dilemmas, after all, often become the subjects of extended discussion in an emergent program's evolution. We hope that our analysis can nevertheless serve to illuminate and sharpen the underlying character of these discussions when they occur. In this sense, our analysis can also be said to offer for other similar programs a preview of some of the associated discourse that may arise over the early course of their experience. Ironically, the strains and dilemmas we describe may also serve to create positive and culture-building experiences for the program, as we will see below.

In September 1990, Contra Costa County's Health Services Department (HSD) won a 5-year, \$2.5 million grant from the Office for Substance Abuse Prevention (OSAP). This OSAP grant award launched the county's Community Partnership project (hereafter, the partnership), whose goal, broadly defined, is to encourage the formation, development, and, thereafter, the existence and vitality of grassroots, community-level organizations and initiatives aimed at preventing or minimizing problems relating to alcohol and other drugs (AOD) within the county. The partnership grant also mandated that an ongoing evaluation component, running the duration of the project, be included in the project's design. The HSD contracted with a local evaluation-research firm for this component, and, along with the reporting requirements OSAP called for, asked the evaluators to generate a series of annual reports chronicling and analyzing the partnership's interim progress. These annual reports were to be aimed primarily at a county readership and intended to offer helpful feedback in the emerging partnership process. The authors are two members of the three-person team of part-time evaluators who are carrying out this evaluation.

The present paper has been abstracted from the first of this project's annual reports (Hunt et al. 1992), which took the partnership's history to the end of calendar year 1991, and to which the interested reader is referred for further information and detail.

On one level, the partnership reflects an endeavor to match and choreograph local and Federal aspirations and activities. Both sides of this partnership make efforts to serve the needs and hopes of the other. In the present case, the interaction between the two begins with a perceived serious community problem on one side, and the birth and shaping of a Federal prevention agency on the other. OSAP gives form to its willingness to help by offering resources, and these resources must be gotten through time-honored procedures that apply not only to OSAP grants but to many federally funded programs. Thus, the cooperation between OSAP and the county level is inevitably structured and transformed by the procedures that define that interaction.

OSAP's Community Partnership program is built on relatively explicit philosophical foundations from which a number of its main programmatic features may be said to derive. Perhaps the core of the enterprise rests on three main value commitments: localism, normative change, and community building. By "localism" we mean simply a commitment to autonomy and control being exercised at the local level rather than the Federal or State levels.

Local government, local agencies, and local citizens are regarded as far better students of local community problems and agents of local change than are far-away State or Federal bureaucrats. "Normative change" refers to the partnership's commitment to transforming the normative environment—the world of shared "rights" and "wrongs"—associated with AOD use and/or misuse in local communities. "Community building" refers to the partnership's endeavors (1) to broaden the base of agency and citizen involvement and action in this problem territory and norm-changing enterprise, (2) to choreograph and coordinate that broadening so that the resulting diversity of membership, thought, and action does not, in turn, bring divisive or even self-defeating results in its wake, and (3) to leave behind a self-sufficient infrastructure for ongoing community initiatives with respect to AOD problems after OSAP support has left the scene.

Broadly pictured, much of the basic form of OSAP's Community Partnership program derives from these three underlying value commitments. Localism, for example, has implied that the partnership support action at the lowest available community level and that the reins of that action be, as much as possible, placed into the hands of local leadership. These commitments lend the partnership program its strong programmatic inclination toward the empowerment of local agencies and persons.

Given that the partnership program's philosophy places a high premium on supporting and expanding both local initiative and local control, it is not

surprising that the program's architects would seek to place this grant support in communities that had histories of locally initiated action before the partnership program came on the scene. Just such a record of previous activity, after all, helps vouchsafe the community's interest and "sincerity" with respect to its partnership proposal and provides one measure of the community's competence and experience in carrying out the proposed lines of action. Put otherwise, a community in which no preexisting enterprise had emerged is also probably one in which OSAP's energies alone would not have gone far in marshaling community energy and participation. Also, by meshing its energies and enhancing existing local efforts, OSAP can hope to achieve greater impact for the same support expenditure. This premium on past activity and locally spawned organizational structure is evidenced in the OSAP Request for Applications' demands for seven local groups and a strong track record of past activity. Contra Costa County has a rich history of past community-level involvement, and indeed its OSAP award ultimately flowed to and through organizations that were the product of the previous substance abuse prevention efforts.

But the desirability or even the requirement of such a prehistory of action and organizational structure also implies latent threats to OSAP's vision of the partnership process. The community's history of concern—as expressed in voluntary organizations and officially sponsored groups and enterprises—makes for a preexisting structure of organizations and concerns. These, in turn, imply preexisting orientations, focuses, and loyalties that may be, in one degree or another, different from OSAP's. In this sense, the partnership's prehistory premium may compete with the project's manifest objectives.

Moreover, to the extent that OSAP's partnership program is committed to a community-based and grassroots ethos, any disjunction between preexisting community groups and the intentions of OSAP will be regarded with some ambivalence on both sides. After all, strains between preexisting structure and inclinations, on the one hand, and the new partnership's agenda, on the other, can be regarded as merely raising the general question of whether OSAP's or the community's aims and plans should be granted primacy.

OSAP's anticipation of this very dilemma no doubt was one of the reasons it initially defined the partnership program only relatively generally—even vaguely—and around participatory rather than substantive goals. OSAP's community-based orientation has given the partnership program its unusually flexible, open-ended, and locally controlled character. (Obviously, one could not attempt to field a Federal program intended to stimulate local interest, creativity, and responsibility regarding AOD problems and at the same time design one that imposed a step-by-step, item-by-item regimen on the program's grant recipients!) Indeed, only the broadest features of the community's obligation to OSAP are described in the partnership program's grant award.

Yet broad guidelines also pose management dilemmas. General and vague program descriptions may leave the partnership's official leadership — here, lodged in the county's health bureaucracy—with little guidance or authority for imposing appropriate monitoring and control measures. For example, in Contra Costa County an early controversy arose in the partnership concerning the appropriate process by which a new project director should be selected and appointed. A steering committee composed primarily of HSD staff had taken the lead in the selection process and before long had chosen four finalists. Regional representatives, however, challenged the centralized and county-government-led character of this selection process. They also contended that HSD staff had not allowed for adequate input from regional or local action groups—that is, from the partnership's community-based or grassroots contingency. County staff, in turn, defended the selection process they had employed, noting that regional representatives had been offered, but appeared to have declined, participation in the selection process early on. After considerable discussion, the HSD director, himself, intervened. He decided to reinterview the staff's list of finalists as well as any other candidates offered by the regional representatives. The HSD director finally appointed one of the original finalists to the project director post. This cameo illustrates how the absence of clear authority or procedural guidelines and the partnership program's emphasis on grassroots and community-based organizational ethos combined to engender controversy over collective partnership acts and decisions.

As noted already, the partnership embodies the notion that far-away bureaucrats in Washington cannot provide solutions to the country's AOD problems. Those solutions, the partnership program suggests, must come from the vision, energy, and commitment of the citizens of local communities. Yet, Federal resources—that is, funds, symbolic endorsement, technical assistance, and the like—are being employed to stimulate and support local endeavors. Incoming Federal money naturally and inevitably involves the responsibility of accountability for its use. Accountability, in turn, implies the need for structure—that is to say, the designation of agencies and persons responsible for the support's proper and effective use. Responsibility, in turn, implies the need for clear hierarchy—places where, so to speak, the buck stops. But the creation of hierarchy and structure may run against the grain of the grassroots, egalitarian, and volunteer character of the sought-after community effort. For example, accountability may be more easily achieved by lodging responsibility for the project in the hands of a county government office—even though that locus may strain the nongovernmental emphasis in the partnership concept. Or, accountability may imply the need for rigorous control and monitoring of expenditures, implying strong leadership—even though strong leadership in this area may chill the otherwise spontaneous and egalitarian character of the program.

Whatever else it may be, OSAP support is also a new financial resource to

the recipient community. This resource, in turn, will inevitably come to be regarded as a prize that different persons, agencies, and community factions will vie for competitively—in a contest made all the more vigorous by tight governmental budgets. That competition, in turn, will occasion frictions over the alternative rationales and methods by which the money will be allocated, the actual process of allocation, and the final results of the allocation. This, in turn, can create divisive or centrifugal rather than centripetal forces within the county—occasioning turf jealousy, wasteful disputes, and lingering bruised feelings where enhanced cooperation and solidarity were, of course, the intended effects.

Federal support that is in turn administered by a county agency, that is in turn intended for the assistance of local communities and citizens, may also create confusion about in whose interests and by whose standards the resources are supposed to be used. Interests and expectations of higher levels (OSAP, California State government, county government) will at times be at variance with those springing from the grassroots. There may even be differences in perspective within the county—say, between a countywide institutional layer and the regional (and even subregional) institutional layers. This type of center-periphery strain became apparent within the county once the grant was allocated region by region. Having obtained their share of the funding, each of five regions pursued agendas partly reflecting plans they had devised before the partnership commenced. The diversity thus engendered may create difficulty in coordinating the overall program at the countywide level.

Culture-Building Experience

It would be inaccurate to suggest that these sorts of strains and dilemmas were the only structural developments occurring in the Contra Costa Community Partnership over its first year. On the contrary, there were also a number of countervailing tendencies, which can be summarized under the heading of "culture-building experience." "Culture," here, is intended to convey the notion of a common perspective on AOD problem prevention, a common conception of process, a common vocabulary, and a common view of action. Some of this culture-building experience was inadvertent and unintentional while some of it was quite intentional and deliberate.

Ironically, even the dilemmas themselves contributed to the culture-building experience, if only inadvertently. Each strain or dilemma inevitably occasioned exchanges, discourse, and negotiation about the proper norms for use in its resolution. Such discourse and the resolutions to which it gave rise inevitably served also to establish a "culture" of past experience—providing precedents, defining legitimate procedures, and successively marking out more clearly the collective character of the partnership endeavor. In this sense, strain-related conflict can be said to have contributed to an emergent common culture.

OSAP's program of training directed at program participants constituted deliberate and much discussed efforts to build a common partnership culture. In light of some of the limitations operating on OSAP in its community-based partnership program and its conception of locally initiated action, it is perhaps not surprising that OSAP turned to "training" as the preferred device for maintaining some sort of directive capacity over the emergent project. A dozen partnership participants attended OSAP's 5-day training program, which was staged in San Diego, 600 miles away. By most accounts, the training provided a rich and meaningful experience for participants and was regarded as a big success.

By its end, moreover, the training experience had generated a strong sense of camaraderie among the participants. When the Contra Costa training graduates arrived home they exhibited not only a new spirit and a new purpose but also a new feeling of togetherness. This new solidarity, however, also caused the trainees to see themselves to some extent as a group apart, not only because they had learned a new way of looking at substance abuse prevention, but also because they were now bonded together by their common experience. At least for some of the training graduates, the San Diego experience was described in epic terms. According to one, the group members were now the "chosen ones who had gone through a 'melt down' in San Diego." They had learned both a new philosophy and its vocabulary. Such concepts as "community," "empowerment," "grassroots," "top down/bottom up," "inclusion," and "paradigm" had taken on more specific meaning and become part of their common parlance.

A major goal of the training was to develop the community-building skills of the participants and strengthen their communitarian and egalitarian sensibilities. Ironically, one of the unanticipated consequences of this experience was that participants in the training returned to the county with a new sense of in-group identity and solidarity. This new sensibility, in turn, inadvertently fostered something of a clique-like and elitist mood—one perhaps diametrically opposed to the intended goal of the training experience. Thus, an enterprise aimed specifically at enhancing the communitarian and democratic aspect of the partnership had the odd result of also enhancing an exclusionary sensibility among an emergent leadership group. A new sense of group identity among graduates was evidenced in a variety of ways. Shortly after their return, San Diego graduates began—perhaps tongue-in-cheek—to refer to themselves as the "Founding Partners." As this name suggests, the group now saw itself as the progenitors of a new partnership tradition and trajectory. Graduates also consolidated themselves into a newly denominated leadership group—the Community Support Committee (CSC)—which subsequently exercised increasing authority over partnership plans and activities.

The emergence of a new leadership core built around the training graduates rekindled older, ongoing discussions regarding the proper character and di-

mensions of the partnership's leadership structure. Returning graduates sought both to retain and consolidate their new group identity and, at the same time, effectively diffuse what they had learned from their training to a larger home group. However, encouraging a large home group to enter into the new leadership circle ran the risk of creating an unwieldy leadership structure. Too large a leadership group would, of course, introduce problems of manageability and efficiency. The issue was often debated in CSC meetings. The case for retaining a small leadership group—built around the CSC—rested on the notion that this group represented a powerful cadre whose effectiveness was derived from its common training experience. On the other hand, this new elitism was perceived to run counter to wider OSAP premiums on inclusiveness and broad community participation.

Conclusion

OSAP's partnership program, we have suggested, is built on value commitments that to some extent imply a philosophical buffer between the Federal agency's assumptions and agenda, on the one hand, and the local level's reinterpretation and actualization of the partnership, on the other. Although this buffer supplies the local community with symbolic autonomy, the impediments of the Federal grant system are as ever present in this program as in any other federally funded programs.

We have seen how OSAP's premium on its grantees showing a preexisting record of local interest and community organization in the AOD problem area can also occasion conflicting orientations, focuses, and loyalties. Such disjunctions between local and Federal agendas, moreover, will elicit ambivalence on both the Federal and the local side—or they raise the difficult dilemma of to what extent, and in which circumstances, OSAP's premium on localism should be valued over its responsibilities to centralized oversight and control.

OSAP may well have sought to minimize the severity of this sort of potential dilemma by means of the flexible, open-ended, and locally controlled character of the partnership program. But that flexibility can also occasion difficulties—as we saw in the procedural confusions surrounding the hiring of a new project director. We have also argued that, whatever else it may be, the OSAP grant award—like any other federal grant—will also be seen as a prize for which community groups and factions will compete, thus occasioning the potential for new conflicts. In these ways, a number of inherent features of the Federal grant-giving domain inevitably crosscut and to some extent thwart the specific philosophical and programmatic commitments of the OSAP partnership program.

Yet, other first-year experience mitigated these strains and dilemmas, too. Ironically, the surmounting of these very conflicts and controversies had a culture-building consequence for the partnership. OSAP's program of training also tended to build a new sensibility of common experience, language, and

philosophy—though, as we saw, an elitism was also (perhaps temporarily) introduced. Indeed, the substance of OSAP's training program as well as the high premium on the training experience lodged in it by both OSAP and community participants may well have partly offered the partnership's participants the means for better overcoming these strains and dilemmas. All these effects are, at this stage, still in flux. Naturally, we look forward to watching how they play out—and how the partnership's participants will resolve them—over the course of the coming year and the full remaining grant period.

Reference

Hunt, G.; Roizen, R.; and Gonzalez, C. *The Office for Substance Abuse Prevention's Community Partnership Project in Contra Costa County: First Year Evaluation Report*. Richmond, Calif.: Center for Applied Local Research, February 1992.

Symposium Plenary Discussion

Sally Casswell raised the question of how resources are best divided between process evaluation and formative evaluation. Kathryn Stewart responded that process evaluation *is* formative evaluation.

Roberta Ferrence, referring to Stewart's remarks about moving from one-shot programs to comprehensive community programs, said in the history of public health the most effective programs often are highly focused, one-shot programs. The ineffective programs usually are those that lack negative or positive reinforcement. As for comprehensive community programs, she believes they will be successful to the extent that such reinforcements are built in. "It isn't enough for the community to feel they own the program," she said. "We have to have a motivation for changes in behavior." This fact is especially true for alcohol programs that do not have a clear-cut consensus behind them like the support, for instance, of a program to eliminate cholera.

Norman Giesbrecht commented on the importance of getting periodic feedback from participants in a program about their perception of the problem and its causes and solution. While Louis Gliksman included this in the needs assessment described in his report, it might also be included in before and after baseline measures to determine if there has been any change in these perceptions. Friedner Wittman said, "I'm uneasy about projects which have not been very well designed at the sponsorship level, nor well supported, even though there may be a lot of money and a lot of activity going on." Stewart observed that community participation in her projects was stimulated at the beginning by the offer of funds to carry them out.

Eckart Kùhlhorn said he was impressed by the integrity of the communities

described in the American experiments. In Sweden, he said, there is a disparity between the way communities describe their prevention efforts and what they are actually doing. Many communities appear to be less interested in solving problems than in attracting favorable publicity for the agency involved in the project.

How Can Evaluations Make Sense of Local Differences?

Local Community Characteristics and Prevention Strategies: The Likelihood of Taking Action on Community Problems With Alcohol and Other Drugs¹

Thomas K. Greenfield and Rhonda J. Jones

Introduction

There is widespread agreement (e.g., Heller 1989; Wallack 1984), echoed by participants at the Scarborough symposium (Giesbrecht et al. 1990), that communities differ in many ways relevant to planning community-based prevention strategies. Communities vary along many dimensions (Room 1990), but the specific variables of importance will depend on the type of program. Generic lists of dimensions have been made (Kelly 1988), but participants at the first symposium lamented the fact that the theoretical and, even more, the empirical specification of variables is not highly developed (Pederson et al. 1990). This research was designed to explore one dimension of particular salience to community-based projects—the potential for citizen action on community alcohol and other drug (AOD) problems.

Community members' level of readiness to take action and the kinds of action they may take are important pieces of information for community-based program planners. Kelly (1988) recommends reconnoitering community traditions for responding to problems; will the "novel" activity be congruent with how things are done in the community? If a community's core values are violated by a prevention program, Kelly believes it will likely fail. Conversely, recognition that a community is not "familiar" with a certain way of doing things implies that if that approach is considered important, it should be introduced as an innovation in a carefully planned manner. For example, when citizen action is called for and activism is "foreign" to the community, citizen education efforts akin to the Saul Alinsky's civil rights organizing in the 1950s might be useful (see Tjerandsen 1980).

We know that community action can reinforce rather discrete prevention programs like Responsible Beverage Services (RBS). Mosher (1991) notes that grassroots citizen groups "are particularly strong allies in designing and implementing RBS programs" (p. 17). The pre-program status of indigenous efforts should be assessed; if absent, "part of the program developer's task may be to organize such a group" (Mosher 1991, p. 17). Citizen education built into

a community organizing project might be essential in an apathetic or disenfranchised community. But one should also consider whether the community might have other ways to bring about changes that are more natural to its traditions. Citizen empowerment is not essential to all prevention campaigns; at times community-oriented researchers work directly as social activists with little or no community participation. A good example involved a researcher's presentation to a city council successfully supporting enactment of an ordinance mandating no smoking sections in restaurants (Jason 1991).

To summarize, for many reasons empirical tools for assessing community readiness would help community researchers and project planners. It would be valuable to have some way of determining ahead of time whether a given community can be mobilized and the level of effort involved. The preprogram need for community development and citizenship education should be measured in addition to community members' preferences for ways of taking action.

Specific Prevention Research Setting

The context for the community action research we undertook was the evaluation of a multisite community-organizing effort sponsored by a new institute, the Marin Institute for the Prevention of Alcohol and Other Drug Problems. At that time, the institute's major mandate was to develop and test innovative AOD problem prevention strategies, especially community organizing, consistent with social justice principles of participant empowerment (Greenfield et al. 1990). The research included a community-involved survey conducted by the institute's research division (for details, see Jones and Greenfield 1991) for needs assessment and a baseline for subsequent programs. Community prevention councils and focus groups assisted in research design and implementation.

Research Questions and Goals

First, we had methodological questions: What were the construct's dimensions and could a psychometrically adequate research measure of the likelihood of taking community action be developed? Second, we wanted to assess the relative likelihood of taking various types of actions—were some approaches preferred over others? Third, from a validity standpoint, we wanted to know how the likelihood of taking action on community problems with alcohol and other drugs varied by personal characteristics and by region of the county (in this analysis serving as a surrogate measure for community).

Fourth, following Kelly (1988), we hoped that assessing the ways community respondents might act if faced with community alcohol and other drug problems—their self-reported likelihood of taking various actions—would provide community organizers with valuable information on community readiness. Such a measure might predict the likelihood of community members responding favorably to calls for citizen participation in local prevention actions.

Finally, we hoped to establish a baseline against which to measure changes attributable to community organizing. As a number of people have noted, "there has not been much outcome evaluation of community organizing techniques" (Greenfield et al. 1990). If community organizing "empowers" people to act powerfully, we surmised that increased intention to act should be a good indicator of program effectiveness. We believed that a measure like this, if psychometrically sensitive, reliable, and valid, could serve as a useful outcome measure for programs incorporating these approaches.

Methods

Survey

Data were collected in a 25-minute telephone interview conducted between July 1990 and January 1991 with a general adult (\geq age 18) household sample of 1,895 respondents in a suburban U.S. county of approximately 212,600 adults. The sample included an oversample of 65 self-identified Hispanic individuals (total Hispanic $n = 140$). Except for the Hispanic oversample, random digit dialing was used (98 percent of households have telephones in this county). Computer-assisted telephone interviewing was done in English or Spanish by trained interviewers supervised at the institute. The cooperation rate (number of completions divided by completions, hang-ups, refusals, and break-offs) was 55.8 percent. Poststratification weighting adjusted for sampling design (based on number of adults and telephones in household) and demographic differences from the 1990 census (gender and age combinations and race). Design effect was estimated to be 1.65, yielding an effective sample of approximately 1,200. For technical details, see Jones and Greenfield (1991).

Measures

The interview—see Jones and Greenfield (1991)—included many measures taken from national surveys (Health and Welfare Canada 1989; Alcohol Research Group 1990; National Institute of Drug Abuse 1988). A 14-item policy opinion scale was developed (Jones et al. 1991) from which four favorability subscales were constructed: law enforcement, advertising restrictions, access reduction, and server responsibility measures.

The brief inventory of actions citizens might take drew on the thinking of a number of community psychologists (Florin and Wandersman 1990; Heller et al. 1984) but especially on a recent study on empowerment (Zimmerman and Rappaport 1988). The latter authors defined the construct as "the connection between a sense of personal competence, a desire for, and a willingness to take action in the public domain" (p. 725). Although our focus was more problem specific, like them we developed a "community relevant scenario," asking respondents how they would likely respond if confronted with such a situation.

The Likelihood of Taking Action inventory was initiated by the interviewer stating:

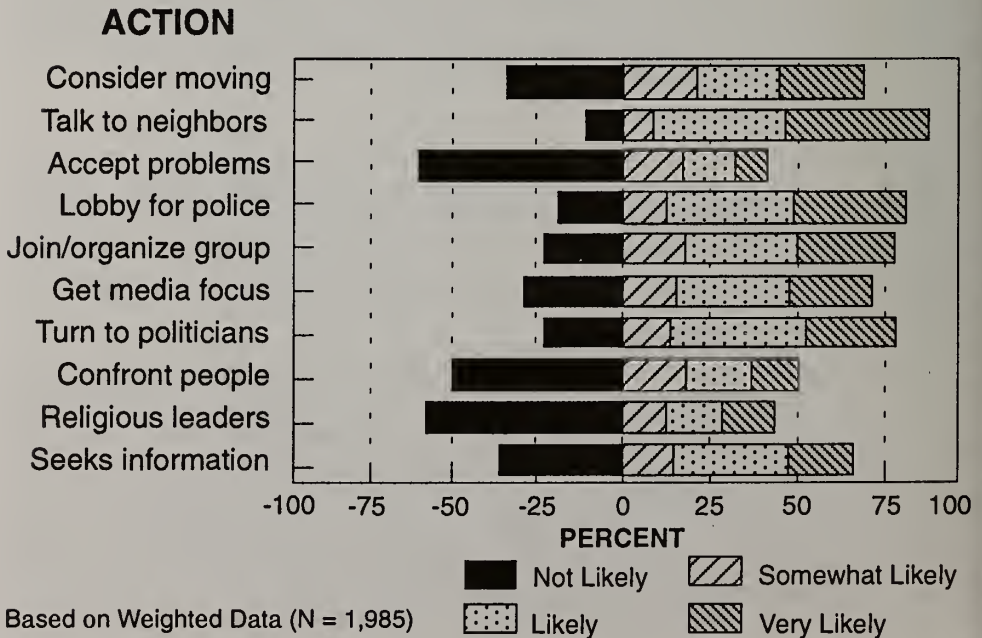
The following are things people may do when faced with a problem in their communities or neighborhood. I am going to describe an imaginary situation and ask what you think you'd do. Imagine that your community is deteriorating because of drug and alcohol use. Please tell me how likely would you be to do each of the following: Would you be *very likely*, *likely*, *somewhat likely*, or *not likely* to...

This instruction was followed by reading the 10 items (verbatim content may be obtained from the first author) and prompting with the four-point Likert-type scale given above.

Results

Figure 1 summarizes the overall likelihood of taking various actions. A majority of county residents (60 percent) reported not being likely to accept the problem and go on living as best they could. But although most reported they were unlikely to be passive, 67 percent were at least somewhat likely and 27 percent were very likely to consider moving away. A majority (58 percent) were

Figure 1. Likelihood of Taking Various Actions in Response to Community Deterioration.



not likely to speak to religious leaders and 50 percent would not confront the people involved in the problem directly (only 14 percent very likely). Otherwise, varying majorities reported some degree of likelihood of taking each of the seven remaining positive actions in the face of community deterioration. Citizens were most likely to talk with neighbors (77 percent at least somewhat likely and 47 percent very likely); more than 75 percent were at least somewhat likely to lobby for better law enforcement, turn to elected officials, or join or organize a community group to address the problem. Although subscribed to by a majority, getting more information from libraries and such and getting the media to focus on the problem were less popular than the other active strategies (see figure 1).

Factor Analysis

Using SPSS (Norusis 1985), a factor analysis of the 10 items of the inventory was undertaken using the common-factor model (Mulaik 1972), first testing for suitability of the model (Kim and Mueller 1978). To examine robustness of the solution under different assumptions, two methods of extraction (principal axis factoring and maximum likelihood) and rotation (varimax and oblimin) were used, rotating factors with eigenvalues greater than 1. Both extractions with both rotations yielded the same structure—a general factor consisting of seven items and a dyad made up of item A, “Consider moving away,” and (negatively loading) item C, “Accept the problems.” Percentages of variance accounted for were 25.1 percent and 4.6 percent, totaling 29.7 percent (for details, see Greenfield et al. 1991). Based on items with loading $> .4$, factor 1 content was heterogeneous. It includes relatively simple coping responses like “Talk to neighbors” and “Get more information” to more committed ones like “Join or organize a group” and “Get media to focus on the problem.” Appeals to external authorities were also included—“Talk to religious leaders,” “Turn to politicians,” and “Lobby for more police.”

A factor-based likelihood of taking action scale of the seven general factor items was created using equal item weights (Kim and Mueller 1978). Reliability analysis supported omitting the lower-loading item H from the scale. Cronbach's alpha was .77, adequate for a brief research scale. The composite scale was constructed so that an individual's score corresponded to the mean item response (provided at least four items were completed) ranging from 1 to 4. Psychometrically, the scale had excellent properties based on 1,941 cases: mean 2.58; standard deviation .70; approximate normality (skewness = $-.148$).

Relationship With Other Variables

The association between the likelihood of taking action score and a number of demographic and other variables, including region of the county, and drinking were detailed in Greenfield et al. (1991) and will only be summarized. Not many variables, from a fairly extensive set that could account for variation, are

associated with likelihood of taking action. Even perceived seriousness of AOD problems was not significantly related to the likelihood of becoming an activist in the face of community deterioration. Only race and education appear related to the scale, and the relationships, although statistically significant ($p < .01$), were modest with less than 1 percent variation accounted for each. Hispanics reported a greater likelihood of taking action than other ethnic groups, with African-Americans reporting the least likelihood. Those persons with less than a high school education say they would be *more* likely to take action in the face of community deterioration.

Categorical analyses were used to examine bivariate relationships with three civic participation variables. In each instance, no relationship with likelihood of taking action was found. It was hypothesized that there might be a relationship between likelihood of acting and opinions about new prevention policy measures. The four policy opinion subscales—law enforcement, advertising restrictions, access reduction, and server responsibility measures—each had nonsignificant correlations with the likelihood of taking action score. Only one of the individual policy items “Increase funding for job training programs and social services” was significantly related to likelihood of taking action, such that those who *opposed* increasing funds for job training and social services were more likely to take action.

Discussion

Findings from our study can be summarized as follows: (1) Most respondents indicated they would take a number of active steps to alleviate AOD problems in their communities. Preferred actions included discussing the problems with neighbors, helping organize a community group, contacting elected leaders, and, to a lesser extent, getting media attention and seeking information. Fewer would involve religious leaders, confront troublemakers directly, or accept the situation passively, although a substantial proportion would consider moving away. (2) Seven of the items appeared to serve well as a general self-report measure of likelihood of taking action. (3) Likelihood of taking action was associated with race and education of the respondent. Hispanics were slightly more willing than African Americans or Whites to take action in the face of community deterioration; respondents with less than high school education were also slightly more likely to engage in action than those with more education.

In our study, Hispanics were more willing than other groups in the county to indicate they were likely to take action in their community. For the Hispanic population in this affluent community, who are less well educated and, in many instances, living in a poorer residential area where many apartment buildings are interspersed with light industry, the scenario provided was probably very plausible and “close to home.” Interestingly, prior to the survey this area with the highest Hispanic concentration in the county had mobilized

around another drug-related issue, neighborhood crime and lack of police patrols. The measure appeared sensitive to this indigenous "activism."

These findings, although preliminary, have implications for the design and implementation of community-based interventions. First, they suggest that constructs such as "likelihood of taking action" may be important dimensions of community life we need to consider when planning interventions. This measure may provide valuable information about different subgroups within a community who are experiencing AOD problems first hand. Groups who are most affected by these problems, if brought into the planning process early, might be instrumental in involving and mobilizing other segments of a community, a process that needs further study.

Second, we believe measures such as likelihood of taking action could provide insight into why there are local differences in program impact. Higher scores among residents in some intervention communities may be an indication of grassroots activity, as was the case in our study. If so, program outcomes may vary to the degree to which intervention activities complement existing local (grassroots) activities.

Third, scales such as the one used in this study can be useful in helping civic and community groups evaluate their own efforts. The data derived from this measure may provide useful feedback to community groups on which segments of their community they can turn to for support, which groups may be more resistant to reducing alcohol and other drug problems, and what types of actions may be most appropriate in their community. Unfortunately, we did not have an opportunity to examine the use of this scale for *outcome* evaluation in the intervention communities. Shortly after the baseline survey was completed (and used within the communities successfully for needs assessment purposes), the institute was faced with a major funding shortfall and evaluation of the institute's community organizing activities was curtailed. We note that such a technological innovation may be difficult to market successfully to community organizers; quantitative outcome evaluation is often (but not always) perceived as superfluous or even antithetical by activists. As Room (1990) has commented, research and action are an unstable mixture.

Based on the preliminary findings, however, "likelihood of taking action" is a construct that warrants further investigation. Our scale was based on a hypothetical situation. Given the imaginary nature of the vignette presented, we do not know if residents would act as reported if community deterioration actually occurred. We can only say that for some communities in the sample, the scenario provided was probably realistic. Future studies may wish to develop measures that assess citizens' responses to real local environments and events: neighborhood billboards targeting minorities or youth, drug sales near school grounds, and the like. The dearth of associations observed here was not expected. More correlational studies are needed to better assess the construct validity of likelihood of taking action and to understand its utility in

alcohol and other drug problem prevention research. Use in conjunction with more qualitative measures would also be vital to this effort.

Note

1. An earlier paper including some of the results reported here was presented at the 17th annual meeting of the Kettil Bruun Society for Social and Epidemiological Research on Alcohol, Stockholm, June 9-14, 1991. We gratefully acknowledge support of this research in part by the Office of Alcohol and Drug Programs, County of Marin, and in part by the Marin Institute for the Prevention of Alcohol and Other Drug Problems, San Rafael, Calif., where the authors worked during the study period.

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Community Response to Drug Abuse: Experience in a Developing Society

Hari Kesh Sharma and Davinder Mohan

Background

The contemporary drug scene in India presents a mixture of complacency and turmoil. The complacency exists in spite of a steady increase in the production and consumption of alcoholic beverages (Working Group 1984) and tobacco (Mohan and Sharma 1989; Mohan et al. 1982), along with the traditional use of raw opium (Mohan et al. 1978) and cannabis in rural areas and their association with social rituals and beliefs (Sethi and Trivedi 1979). The unrest started with the introduction of heroin among the middle class and then the vulnerable sections of the population in the cities. An overwhelming majority of heroin users who sought assistance from existing health and welfare systems both in Bombay and Delhi came from the underprivileged of the society (Mohan et al. 1985).

Drug abuse, like a few other social and public health problems, can also be the manifestation of social disorganization on a large scale in the lower stratum of the city dwellers and the poor and powerless globally (Healy et al. 1985). It is equally important to understand how people respond to these developments locally. Coping with drug problems depends on many interacting factors within the community, ranging from the local perception of the problem to the available resources (Arif and Westermeyer 1988). This presentation is based on ethnographic observation of the natural responses of an urban slum population and documents the strengths and weaknesses of problem-solving efforts at the grassroots level of an affected population.

Sources of Information

The information was collected mainly from two sources. The first source was observations by one of the authors (Sharma) who happened to reside in an area of Delhi with a slum neighborhood. The neighborhood area came into prominence as an area of heroin peddling, and many distress signals were noticed in the community over a short timespan. The second set of information was collected through the institutional network (Drug Dependence Treatment Centre) and the social network of the affected community. A research team from the center carried out field work related to alcohol and other drug (AOD) abuse. These two sources provided a pool of ethnographic descriptions on crisis and the community responses in handling the problem of heroin abuse.

Description of the Affected Community

The observations were confined to three sublocalities within a large residential area. The local press highlighted the heroin-related crimes through sensational

reporting and painted the whole residential area, with a population of 100,000, as a trafficker's paradise. The information gathered, however, suggested that distribution and consumption of heroin and sale of illicit liquor were largely confined to three peripheral sublocalities. The geographical and social characteristics of these sublocalities delineated them clearly from the larger area. They came into existence about 30 years ago as hutment clusters of poor migratory workers from neighboring states who came in search of job opportunities. With the growth of population and continuous influx of workers from rural areas, the hutments turned into congested and overcrowded one-room apartment buildings with minimal civic amenities. At present, these sublocalities have more than 2,000 unplanned houses with a population of about 20,000. The three sublocalities are bounded by a railway track on one side and a big sewerage drain on the other side. The latter did not permit further expansion of the sublocalities and over the years the hutments became urban slums. Each family competed for meager local health and welfare resources, which frequently led to social tensions.

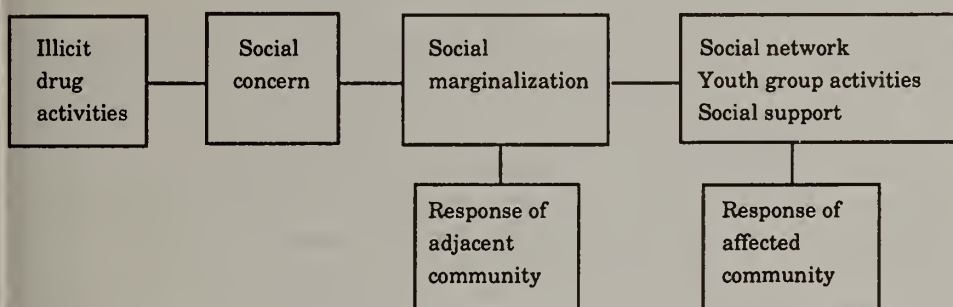
The dwellers also had other distinct social features. A large majority of them were from the lower Hindu castes (scheduled castes and scheduled tribes). The men were engaged in odd manual jobs, and the women supplemented the family earnings but had a minimum role in decisionmaking and family affairs. The population also showed subregional grouping within the areas. There was no single cohesive group with strong affiliations to either caste, language, or place of origin. The subgroup norms and lifestyles further restricted the emergence of a community identity. The young people in these groups shared unemployment and a struggle for survival. They had minimal time for participation in community programs.

In these sublocalities, about 10 families belonged to a nomadic tribal community (*Sansis*), who came in and left each year, contributing the most to the illicit drug trade. The tribe had been identified by the police as having a great involvement in criminal activity. The *Sansis* had acquired this reputation over the generations. The existing social system did not permit free social interaction with this criminal tribe (Mamoria 1965). Before the inflow of heroin, these families were engaged in crimes, bootlegging, and selling of spurious country liquor at a cheap price. In these localities, they took easily to peddling heroin among the youth, because a substantial number of youths were already using illicit alcohol and cannabis. Thus, the necessary conditions for an outbreak of drug misuse existed in this community; along with the availability of drugs, there was already a presence of socializing drug users and predisposed individuals (Fraser and George 1988). Being members of a criminal tribe, the *Sansi* men were not afraid of using muscle power whenever needed and the *Sansi* women developed their own methods to scare the community. Men and women of these *Sansi* families were able to introduce heroin into the area in a systematic and phased manner. By 1985 the financial turnover was substantial. These families were able to spread their retail network from these localities

even to urban villages 10 kilometers away. A case study of an affected village community is presented below, along with the community responses of the slum community.

Community Response to Drug Problems

The response of the whole affected population was not unitary, varied across each sublocality, and was mainly concentrated on the types of AOD problems and on the proximity of illicit sales outlets. The process of community response to heroin and alcohol use is presented below:



Initial Response

Initially, the affected population in these localities had ignored the activities of drug peddlers, as they were also good samaritans, donating and lending money at the time of marriages or other socioreligious occasions. This attitude changed when the residents of the localities were forced to pay heavy social costs on account of the antisocial and criminal activities of the tribe and resultant rise in criminality of the population as a whole. After realizing the gravity of the situation, the residents of the affected areas naturally acted.

Adjacent Community's Response

The key components of the response were enlisting the help of enforcement agencies and mobilizing social support from nonaffected adjacent communities. However, both these sources were inadequate. First, the others blamed the victims and their environment for encouraging these activities. The community leaders and youth then resorted to physical punishment once they got hold of a heroin users-cum-peddlers and even handed them over to police. The local police also found the arrangement convenient and supported the marginalization process initiated by the adjacent communities. They overlooked the drug peddling activities and the potential buyers in the slum locality but acted strongly on any complaint from neighboring communities. In fact, these slum localities became a source of earnings to the local police and antisocial elements on account of peddling.

The resultant social stigmatization and isolation from the neighboring social support systems forced the affected areas to mobilize their own resources. The approaches to tackling the problem, however, varied within the three affected sublocalities.

Long-Term Responses

Sublocality A

Over a period of time the social perception of the locality changed from indifference to hostility toward both the users and peddlers. They located the sales outlets of illicit heroin, *addas* in common parlance, and attempted to isolate them from the sociocultural framework. With the increased demand for heroin from 1985 onward, a new set of marketing and social forces operated. The number of heroin users increased manifold and a large number of people, both genuine buyers and antisocial elements from other parts of the city, began to swarm around these *addas*. There was no time restriction for the peddling trade, which continued throughout the night. Drivers of vehicles stopped in the heart of the locality to buy heroin, and users roamed around in groups. Petty thefts, quarrels, and other antisocial activities increased. In fact, this area became synonymous with criminal activity.

The responsibility of action ultimately fell on an unorganized youth group. The youths realized the cost of social deprivation, marginalization, and stigmatization to them. It peaked when even marriage proposals from the area began to be refused. The anger was also directed toward the local police, because they were ineffective. The youths even suspected that the enforcement had been bought over by the traders, as illicit drug business was going on openly. It was a daunting and risky task for these youths to take on these antisocial elements. The local community leaders advised them to restrain their activities and not take the law into their own hands. However, the murder of a youth in an adjoining area on account of this trade charged the atmosphere. The strategy of the youths was simple: just play a vigilante role against the customers by not allowing their vehicles to pass through or not allowing any drug user in their bylanes or streets to obtain a supply of drugs. The youths aimed to make this area drug free. A senior police officer of the area became equally enthusiastic and sympathetic to their cause. The youths also sought the help of other voluntary organizations and government agencies working in the field of drug dependence, including the team from the Drug Dependence Treatment Centre.

For the first time, the peddlers were being threatened on their home turf. The peddlers showed their strength and muscle power. About a dozen peddlers challenged the community to stop their business. A scuffle and fisticuffs occurred, and a few people from both sides were injured, but the *diktat* of peddlers was broken. The police then intervened and the youth group succeeded in getting the peddlers arrested. The battle was half won. The youths continued the pressure for many more months, and vigilance continued. At

present in this area the drug peddling activities have come to a standstill, but for how long? The unknown became the heroes for a while but the credit was usurped by the law enforcement agencies, the few self-styled community leaders, and voluntary organizations working in the area.

Sublocality B

Sublocality B was another cluster of 500 households with a population of 8,000 situated just across the railway tracks in the area. The main problem of this locality was unauthorized sales outlets of army-supplied rum (42.9 percent ethanol) and illicit liquor. The locality had semiurban characteristics, inhabited by people belonging to scheduled caste and other backward classes—kith and kin of the people of sublocality A. Because of the availability of alcoholic beverages (both licit and illicit), the locality had a large number of problematic alcohol users and a few cases of cannabis and heroin users. During the survey work carried out by the research team and the interviews with a cross-section of the population and community leaders, it was noticed that this population had an egoistic attitude. They were more keen to solve the alcohol-related problems of their own locality than to provide social support to mobilize the neighboring locality affected by heroin sales. They ultimately succeeded in achieving their own goals when they built an infrastructure in collaboration with the Drug Dependence Treatment Centre. These efforts led to the establishment of community outreach services for persons dependent on alcohol and other drugs. The formal services began in June 1990. Initially, the outreach service was seen as an achievement by the community leaders but the objective assessment showed that despite establishment of these accessible services, community participation was minimal. The community leaders took the initiative at the commencement of these services but failed to harness support to initiate prevention or control over availability of alcohol through unauthorized sales outlets. The second problem was that a few of the community leaders were problematic alcohol users themselves and thus had limited credibility with the community. The youth group blamed the social environment, which facilitated and tolerated the consumption of alcohol and drunken behavior. These deficiencies led to the failure to develop adequate response toward alcohol as was the case against heroin in sublocality A.

Sublocality C

Sublocality C, comprising 400 one-room dwellings and a population of 4,000, was situated just 100 meters away from sublocality A. The sublocality was equally affected by drug peddling activities and use of illicit liquor. The residents were uniformly apathetic toward these developments. They did not show any concern or take any steps in self-organization despite the presence of a large number of alcohol and cannabis users and two sales outlets for heroin. The main reason for the apathetic attitude was the perceived permissive functional role of alcohol use among the majority of men. Most men in this

sublocality engaged in animal slaughtering and dominated community affairs. They were content with their present lifestyles, a reflection of their own social deprivation and limited role expectations. Even an awareness campaign against AOD misuse by a voluntary organization did not help much.

Response of a Distant Village Community

As described earlier, drug peddlers operating in the slum community extended their activities to adjacent villages and, in this section, the observation of an affected village is presented.

The village, with a population of about 10,000, had a mix of both rural and urban lifestyles. The prevailing caste system determined the social power and hierarchy as well as social interaction among different groups. The village council (*Panchayat*) was the main body of elected representatives for economic development and settling local problems. In the last decade, the socioeconomic structure of the village changed rapidly when the cultivated land was acquired at an exorbitant price for urban development. This sale provided disposable income leading to excessive consumption of alcoholic beverages (Deb and Jindal 1974; Mohan et al. 1980). The excise and revenue department opened a liquor vending outlet to meet the rising demand of this section of the population. Heroin peddlers found a ready market among the youth. A religious leader's sanction of cannabis use gave another opportunity for men to indulge in polydrug use.

It was assumed that traditional control mechanisms and the *Panchayat* would be of vital importance in containing the twin problems. The village community, however, did not become alarmed despite excessive consumption of alcoholic beverages or the disruptive nature of drinking. A majority of the leaders expressed their inability to control the problem of alcohol because most of the men consumed alcohol. There were close kinship ties in the village and although everyone felt concerned about drug use among the young, no collective action was taken. In the evening, there were frequent episodes of drunken brawls, but no one dared intervene. The advice of elders and village consent were ignored. No one was ready to admit to cannabis use as a problem; its use was considered to be a token of religious faith and social discourse.

The helplessness of the village elder community was ascribed to the social nature of AOD problems. According to the elders, it was easy to start a campaign against AOD use, but to sustain the momentum the cooperation of all sections castewise was necessary; this was not possible to achieve. There was another danger: If the issue was not handled carefully, it could lead to other intergroup social problems that would undermine the authority of the village leaders. The disposable surplus income had already created a new power structure. As in a section of the slum population, the weakness of village organizational structure was obvious. The village elders were looking for an external institutional network that could play an effective role in treatment and management of AOD problems.

Discussion

There has been a long tradition of ethnographic research methods in studying a community, the credit for which goes to the Chicago School of Social Research where the participant observation technique flourished. The noteworthy ethnographic studies on drugs came from Dai in 1937, where field research and a psychoanalytical approach were used to study opium addiction in Chicago (Dai 1937). In another landmark in the tradition, Lindesmith (1947) adopted qualitative interview techniques that later changed theoretical perspectives on addiction. Similarly, other important ethnographic works focused on drug use as a "career" (Becker 1963), delinquent subcultures (Cloward and Ohlin 1960), and street dealing and drug trafficking (Fields 1984; Johnson et al. 1985; Adler 1985). Recent work in epistemology emphasized that better understanding of drug-using behavior might be achieved by studying drug users within a particular context (Feldman and Aldrich 1990).

The present communication based on naturalistic responses of an affected slum community and a village helped in understanding community dynamics and social coping mechanisms and their strengths and weaknesses. The community responses varied from drug to drug as did the functional role played by drugs in the lives of individuals and in the group. In the 1980s, when an alien potent substance such as heroin was introduced, the chronic users of traditional drugs found it a convenient substitute without realizing its potential for dependence and long-term health and social sequelae. At the initial stage these strata of the society devised their own defense mechanisms to check the rising problem. It was observed that the affected groups were isolated. The larger social environment marginalized and stigmatized the victims. They were left to fend for themselves by their own fragile social support network and evolve prevention measures. However, there was a commonality in the public response, cutting across national boundaries. The Copenhagen experience, unheard in this community, was repeated in these slum areas. Another village community at a distance of merely 10 kilometers was struggling to evolve even a simple approach in a traditional framework. Donoghoe et al. (1987) described the responses of a community on the same lines. Direct action took place involving confrontation between young people hanging around using heroin and groups of residents who carried out quasi-vigilante activities. There was a sense of social identity emphasizing the strong communal and collective aspects of working class culture.

It is also clear from the above account that in spite of efforts in the community, it is necessary to coordinate the social network with the institutional network. It is too early to arrive at any conclusions because very few community-based programs have been formulated and implemented in our society. The drug dependence problem can neither be segregated from other socioeconomic and health problems nor from the larger social system. No appropriate models have emerged so far.

Acknowledgment

We express our sincere thanks to the residents and youth of these sublocalities, who provided a pool of information on this issue. Our thanks go to the members of the survey team and Dr. Nimesh G. Desai and Dr. Vinay Kapoor for their assistance. Finally, we wish to place on record our gratitude to the late Sh. Tadbir Singh, a member of the research team, for his dedication and untiring efforts in community-based programs.

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Symposium Plenary Discussion

Jan Howard, commenting on Rhonda Jones's report, said that she would have expected that the likelihood of taking community action on alcohol and other drug problems would be stronger in the White middle class than in a lower socioeconomic group as the study showed. Jones said the affluent White population might have felt more removed from drug problems compared with the Hispanic population. Tom Greenfield agreed, but added that the brevity of the telephone interviews (25 minutes) may have been a factor in failing to convey the reality of the scenario to respondents not directly familiar with such problems. He said he thinks this study provides an example of what can be done with more elaborate scenarios to study the potential for community action.

Howard speculated on the relationship between expressing an intention to do something and actually doing it, especially when being asked on the telephone. Friedner Wittman said both of these presentations involved the important question of who should take what sort of action in the face of a problem. He said that Hari Kesh Sharma's presentation in particular pointed out that the style of action and the readiness to act were important ingredients in determining whether action shall be taken.

Robin Room said that while researchers think of their evaluations as contributions to knowledge, they also serve as accountability mechanisms. In the United States evaluations are most often conducted when one level of government is funding some other level, and the evaluations provide evidence of how the money was spent. Room said he saw evidence of that purpose in the projects described by Kathryn Stewart and Geoffrey Hunt. Alternatively, there are evaluations that provide feedback to the community, and the researcher serves somewhat as an adviser to the community.

Shireen Mathrani asked Sharma whether his project might have benefited by trying to get women more interested in the activity. Sharma said he tried to do that, but men in the community discouraged the participation of women.

Tailoring Programs to Communities: Commentary and Reflections on the Day

Robin Room

We've heard several papers today and some extremely interesting discussion. The topic assigned to me, which certainly flows easily out of those papers, is tailoring programs to communities. We can talk about four models of community action at a general level. I suspect this list is not exhaustive, but it at least illustrates models of community action.

One model of community action is the topic of a subdiscipline of sociology called collective behavior, which deals with revolutions, riots, demonstrations, and so on—truly grassroots phenomena that arise from collective decision-making where it's very hard to point, in fact, to who made any decisions in a series of escalating events. That is a model of grassroots initiatives that is uncontrolled, unpredictable, disruptive to the established order, and not something to keep the comfortable comforted. There is certainly a rich history of these kinds of autonomous collective manifestations, and organizations that arise out of those manifestations, in the alcohol and other drug (AOD) field. In the case of the United States I'll just mention the women's crusades that broke out in the Midwest in the mid-19th century as truly an autonomous phenomenon—no outside agitator came to Ohio and caused them to happen. They arose in a context where there already had been 20 years of temperance agitation and thinking, also relatively autonomous and uninvolved with government structures and without any community partnership grants. We can see in Hari Kesh Sharma's paper that this tradition is not confined to one country and still continues. The vigilantes in one of his districts are very much in this tradition of popular manifestation—people deciding to take matters into their hands.

What is the relation of the community organizer, or the researcher, to these outbreaks from the powerless? (That relationship is usually what is at stake in these phenomena of collective behavior.) There is certainly a rich tradition of relevant experience. The labor union organizers in North America in the first decades of this century are classic examples of change-agents moving in to try to help people help themselves in a situation that very often was precipitated by a strike that broke out before the union organizer ever arrived on the scene. As we know from that experience, community organizers who really identify with and try to help in these manifestations of the collective behavior of the powerless are likely to find themselves in a very confrontational relationship with the local power structure. So this model of community action tends to pose to us in its most acute form the fact that there is not a natural unanimity of interests in the community, that there may well be conflicting interests, and that those conflicting interests, in our particular field of action, may well have AOD issues intertwined with them.

A second model of community action is the model that defines the mayor or the town council as the locus of community action. In the case of Shireen Mathrani, she was employed by the mayor and the town council. It is a model of working through the existing community structure. This model also has a distinguished history. I believe that the *panchayat* of the village council has associated with it in modern Indian political thought a kind of romantic vision of the community as a group of people who share common interests. But, as Sharma's paper showed us, the *panchayat* of the village council turned out not to be a terribly powerful mechanism for community action, again because by and large at the community level, the existing structure was rather resistant to anything that involves any substantial changes.

We have heard in the North American experience discussed at this conference a kind of parallel romanticism or nostalgia about the community that often infuses a lot of our thinking about community action. In fact, the decision to go through the existing local structures has many advantages to it for the community organizer, but it is a decision that carries with it limits. Going through the existing structures means that it is only going to be easy to tackle problems that are identified with the powerless in the community, whether it be teenagers, women, the *raggare* in Borgholm, or illicit producers as in the case of the community response experience in Zambia that we talked about in the Scarborough meeting.

So going with or through the movers and shakers carries with it limitations, certainly in the target populations but also to a considerable degree in terms of modalities of action, particularly if one is operating on a model of consensus where all those who have been invited into the decisionmaking process have to sign off on it. I think Mathrani's paper on Oxford offers a very telling example of this situation: pointing out to the power structure something as simple as it would set a good example concerning alcohol in the workplace to *not* build a tavern in the city hall. This action turned out to be something that raised a good many eyebrows.

The third model of community action that I can discern I am calling, rather unfairly, the British model. If you look at Tether and Robinson on preventing alcohol problems in the community, their view of the model of community action is that you deal with the local professionals. You talk to the doctors, you talk to the social workers, you arrange a committee where these folk get together and liaise. You can read the whole Tether and Robinson book and find no mention of anyone who does not in one way or another have a professional position in the community. As I said, it is really unfair to call it the British model, because it is a model that is widespread in a number of the cultures at this meeting. It is a comfortable model for a community action researcher because it means that professionals only have to talk to professionals. It is also a path that encounters relatively little resistance from the point of view of doing research—as long as you aren't studying too closely what the sacred

professional act is for each of the professions—because professionals are friends of research, by and large. But it is a model in which the ordinary community member tends to be defined in a passive role—not as an actor, nor even as a voter, but as a client or consumer absent from the community action process.

A fourth model of community action is the model of money from the outside as the crystallizer of community action. This model seems to be particularly a U.S. phenomenon. We can guess that it might be in general more a phenomenon of federal countries than it is of countries that do not have a federal structure. Often in this world one level of government is trying to reach around another level of government in one way or another by offering resources. The exemplar in the United States that kept recurring both in the discussions in the main meeting and in some side discussions in the last couple of days is the War on Poverty during the 1960s. It struck several of us that there are many lessons for our present purposes to be drawn from the history of the efforts to ensure the “maximum feasible participation” of the poor in the community organizing and community development work that went on in the late 1960s and the 1970s in the United States.

We seem in some ways, to judge from Geoffrey Hunt’s and Kathryn Stewart’s papers, to be recapitulating that history in our own special little world of alcohol and other drugs—in terms of the idea that offering resources, often for a limited time, to a local community was a way in which you could organize community action and solve the problems of the community.

As a participant in the International Collaborative Study of Alcoholics Anonymous (ICSAA), I would contrast this model with the lessons that Alcoholics Anonymous (AA) can teach us about how to organize ourselves to do things. Alcoholics Anonymous would make Kropotkin proud. It is really an organization that is as close as anyone has come, to my knowledge, to being a true anarchic organization: mutual help in its pure form with no outside funding, no alliances, no professionals, no property. It was actually John D. Rockefeller, of all people, who said “I think money will spoil this.” You can argue very much that he was right. The thing that is really peculiar about Alcoholics Anonymous as a phenomenon that grew up in the American society is that it does not own any property. Even churches in American society spend a great deal of energy and internal dissension over the property they own. But Alcoholics Anonymous, as Eckart Köhlhorn and I and others involved in ICSAA have seen, has quite systematically set out to avoid those problems that come with the parceling out of resources in an organization—by essentially not having any resources. There are some quibbles to be made around the edge of that statement, but AA still is exemplary, I think, of a model that can work in a society like ours. Of course it works better with middle-class folk than with poor people, but it is a model that seems to be able to work also in an environment of poor people—it has a million members in Mexico.

It is true that AA offers us a model of an autonomous organization that is not directed at community action but rather is directed internally. But perhaps it still might offer us some lessons about an alternative to the model of "let's try to organize the community by putting some money into it."

Now, what about the role of the community organizer or researcher with respect to these models? Obviously, there are going to be big differences, depending on which model is at stake, in terms of to whom you are responsible, in terms even of the ethics of what you report. Do you report the minor corruptions you discover in the city council minutes? That will depend largely on whether you are responsible to the city council or responsible to those in the community who define the city council as the enemy, or at least not as their friend. So there are going to be very different choices even at the ethical level.

There are also going to be differences in how you design any evaluation you are going to do and how it is reported. In this regard it struck me as interesting how Tom Greenfield and Rhonda Jones set about studying community readiness. Basically, they operated with a methodology where they used survey research. Now survey research is, if you like, an inherently democratic methodology, in one sense of the term. Everyone gets one vote in survey research—if you are included in the sampling frame. (Presumably children do not get a vote if you limit it to age 18 or above.) So this is a model of community opinion and how to define community readiness that is very much attuned to weighing the powerless' opinion equally with the powerful's opinion. It is not a model, in other words, that maps very easily onto, say, working with the city council. City council members may be interested in what their constituents have as their opinions, but the survey is still not going to predict very well how the city council is going to act on some particular issue.

The issue of who owns the community—not only who is the community but who owns the community—is thus posed in the most acute form by the methods that we choose to use in doing our studies, with survey research being at one extreme as a methodology that imposes a kind of mechanical democracy, and a key informant study that interviews only the movers and shakers perhaps being at the other extreme.

So the answer to tailoring programs to communities turns out to be not only that there are huge differences between communities, which is the obvious comment that you can make, but also that the model you have for action in the community holds great implications for the relation of a researcher or a community organizer to segments of the community and to the community as a whole. It also holds great implications for what would be the appropriate methodologies to study when and under what circumstances the intervention has an effect.

Symposium Plenary Discussion

Jan Howard questioned Robin Room's description of Alcoholics Anonymous as an "anarchic organization" in view of what she referred to as the "strong religious theme" of AA. Room responded that, in his view, the reference to a "higher power" in AA was to say that no human being was going to be in charge—that the decisions were to be made by the group conscience, under the guidance of a higher power. Thus, even the spiritual content of AA, he said, contributes to a systematic attempt to avoid bureaucratization.

Commenting on Room's dichotomy between local alcohol programming "above the line" and "below the line," Friedner Wittman said he wasn't sure that going through the mayor or local organizations of a community and going to the grassroots through neighborhood organizing necessarily represented two tracks into the community. One of the aims of the California projects with which he is involved is to bring groups and individuals who have power together with groups and individuals who do not have power.

Paul Duignan questioned whether using the "British model" described by Room was as easy as he made it sound. Talking to licensing bodies, city councils, and especially people in the alcohol industry can be a great challenge to community organizing. Room responded that in Britain and Australia, where there is a national health service, family doctors increasingly have taken on a public health consciousness. "The local professionals become a kind of outpost for public health thinking," he said. His point was to make a distinction between working with professionals and working with the local power structure.

Geoffrey Hunt made some observations about the different stages of the U.S. war on poverty. Early on, money was given to local organizations largely with no strings attached. Local communities used it for empowerment and started to knock at the doors of the power structure. In the early 1960s the Federal Government was lobbied to make the money available through local municipalities with more controls. He wonders if the term "community partnership" amounts to rhetoric without substance and whether such partnership is intended to bring about any real change.

Room said his reference to "revolutions" might have been distracting, and that researchers were really referring to autonomous social movements. Examples in the United States would include Mothers Against Drunk Driving and the parents' movement regarding drugs. Although efforts have been made to co-opt them, they essentially grew up outside the power structure. "There are genuine popular movements around alcohol and drug issues in many of our countries," Room said. "They tend to make researchers and professionals extremely uncomfortable because they aren't controllable and they very often don't think the way we do, and furthermore they are difficult to study."

Wittman added that he thinks the community planning efforts taking place in the United States are themselves a movement, reflecting a devolution of power from the State governments to the localities. This example shows how national movements or developments can produce local expressions that look like community initiatives.

Eckart Köhlhorn, commenting on the idea that survey research is very democratic, noted that it is possible to design survey questions to produce the answers you want, and that survey responses do not necessarily correlate with behavior. There might be better methods to use than surveys to study the "democratic reality" of behavior, he said.

Howard questioned whether the prevention movement should be considered a social movement comparable to the labor movement or class struggles or civil rights struggles, which have a fundamental economic base. Room responded that while alcohol and other drugs are issues somewhat peripheral to larger social issues of the day, they are "a wonderful symbolic arena" in which larger issues of everyday life are often fought. Alcohol issues may become entangled with larger issues as was illustrated in Poland or in California where the African-American and Chicano communities united in a prevention activity. "It was extremely reminiscent of something that might have gone on in the course of the labor movement or the civil rights movement."

CHAPTER 6

Transfer From the Field: Citizens/Community Organizations Implementing Interventions

Sustaining Interventions in Communities: The Rhode Island Community-Based Prevention Trial

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Finding ways to stimulate long-term community action to prevent alcohol and other drug problems and their sequelae is one of the most important challenges facing prevention research. Interventions that are effective but can only be maintained with strong external support are certainly of interest, but interventions that communities can and will maintain on their own have obvious advantages. In 1984 a trial was initiated to reduce alcohol-related mortality and morbidity using a package of community-level interventions selected in part because the intervention community in principle would be able to continue them without major external support. The project has been described in detail elsewhere (Harrington et al. 1989; Rhode Island Department of Health 1989a, 1989b; Stout, in press). Below, we provide a brief summary of the project, including a history of the interventions and their subsequent impact on the intervention community. We also contrast alcohol-related prevention efforts in the comparison communities with those in the intervention site. The successes and failures in this study provide lessons for future investigation.

Project Background

Three communities were selected for the project based on size, incidence of alcohol-related health problems, demographic characteristics, community resources, and other factors. The demonstration community, Woonsocket, was selected at random; the comparison communities were Newport and Westerly. The intervention strategy was to change the knowledge, attitudes, and enabling behaviors of gatekeepers—mainly servers and law enforcement officers—in their roles as regulators of community drinking practice. Three main intervention efforts were supported by project funding and staff: (1) community mobilization, (2) training in responsible service of alcoholic beverages, and (3) increased and improved liquor law enforcement. The intervention effort was named Stop Alcohol-Related Injury through Voluntary Effort (SAIVE).

Community Mobilization and Publicity

The first step was to mobilize the influence of civic and political leaders behind the program. The city council was one focus of the efforts because of its role in controlling liquor licenses. When Woonsocket was chosen as the intervention site, the community coordinator was invited to participate as a member of the Mayor's Task Force on Drug and Alcohol Abuse, which was created in 1986 shortly before the project intervention period.

Responsible Alcohol Service/Training

The second intervention effort was designed to secure the cooperation of owners and managers of package stores, bars, restaurants, and private clubs in a program to increase responsible alcohol service. Owners of liquor establishments were asked to adopt a written policy endorsing principles of responsible alcohol service based on Rhode Island dram shop laws. They were then asked to have their personnel participate in a training program developed by the National Highway Traffic Safety Administration (NHTSA). This program taught servers techniques for identifying minors and intoxicated patrons, and for denying, slowing down, or cutting off service to patrons. The training program also informed the servers of their legal liability if they failed to obey dram shop laws and taught them ways to protect their customers' safety.

More Intensive and Visible Law Enforcement

The third intervention was to secure the support of the chief of police and other law enforcement personnel for programs to increase arrest rates for driving while intoxicated (DWI) and other liquor law violations and to reduce levels of drinking and driving. Police officers were trained (again using NHTSA materials) to recognize intoxication in drivers, operate breathalyzer equipment, and conduct sobriety checkpoints. The police were encouraged to increase radar patrols, sobriety checkpoints, and selective enforcement visits to liquor establishments. We were careful to bring increased liquor law enforcement into effect only after developing the training program for the servers, and we took special care to bring together police and licensees so that each could see how the other was working to solve the same community problem. This coordination minimized hostility between the two groups and, we hope, served to make the two interventions together more effective than either done alone.

Implementing the Interventions

By the end of the demonstration period the following objectives were achieved:

- Written policies for responsible alcohol service were adopted for 100 percent of off-premise establishments and 79 percent of on-premise establishments.

- A total of 388 sales and service personnel, 61 percent of all servers, had been trained in the techniques for responsible alcohol service.
- All members of the Woonsocket police force had received training in recognizing and measuring intoxication, the role of alcohol in police work, police liability in dealing with intoxicated citizens, and on-scene investigation of motor vehicle crashes.
- The police department had initiated 73 sobriety checkpoints, 47 additional radar patrols, and 11 selective enforcement patrols covering 300 visits to liquor establishments.

Continuation of Prevention Activities

As part of the research protocol, a series of qualitative interviews were conducted with key figures in all three communities in summer 1991. The results of these interviews and some data from other sources are summarized below. Although we cannot quantify the findings from these interviews, we believe the information to be reliable.

The termination of intervention funding affected but did not eliminate prevention activities. For example, after the loss of project funding for the interventions, the Mayor's Task Force allocated \$6,500 in the first year to hire trainers to continue server training and to provide support to the police department for selective enforcement patrols. Prevention activities in Woonsocket and the other communities are now largely supported by the State of Rhode Island under the Substance Abuse Prevention Act (Bramley bill). This law, which was passed in 1987 and implemented in 1988 toward the end of the experimental intervention period, provides funding for local task forces in all 39 Rhode Island communities. The Woonsocket Mayor's Task Force continues to fund half the cost of server training; however, the emphasis on this area is declining because most servers are already trained, even allowing for turnover. The city has not, however, had enough resources to maintain the program of radar patrols and sobriety checkpoints. Special patrols have been reduced. Roadblocks were banned by a court decision, but probably would not have been maintained in any case. Checking of bars has been reduced. The task force wants to improve law enforcement efforts, but at present lacks the resources to do so.

With regard to mobilization and communication, the Mayor's Substance Abuse Task Force remains active despite the fact that the mayor who had been a strong SAIVE supporter lost an election and the current mayor has not been as involved in task force activities. There is, however, still communication and coordination among police, owners and servers, and other community groups. There is a high level of awareness among task force members of the importance of alcohol problems.

Several prevention activities that were not part of the original SAIVE protocol are being conducted in Woonsocket. Programs targeted at youth are now a priority. These include Red Ribbon weeks, DARE (a drug prevention program that involves visits by police officers to schools), student counselors, media efforts targeted at adults, and a program for health workers to intervene in areas where there are many young people at high risk. Natural Helpers peer counseling was implemented for a time, but was dropped during 1991–92.

Comparison of Communities

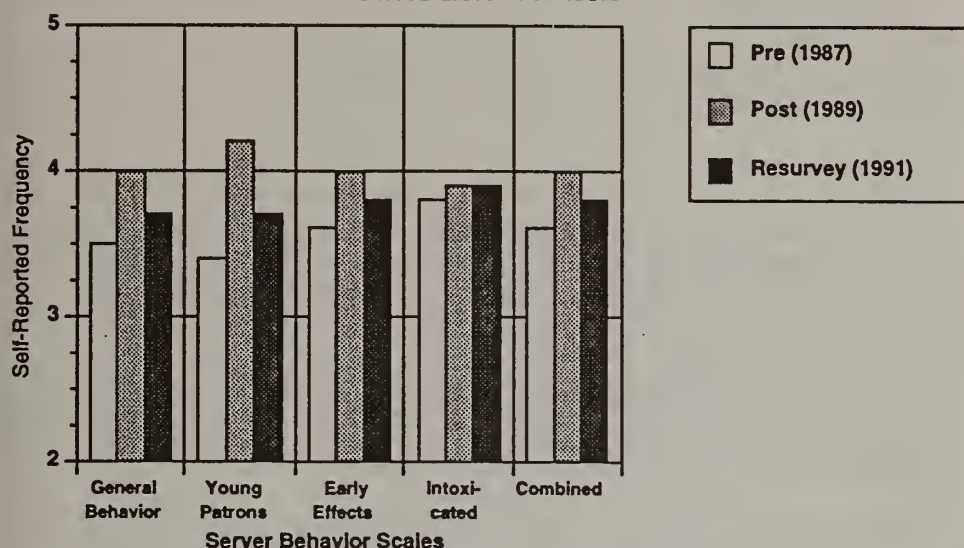
The three study communities were selected to be similar with respect to broad demographic and institutional characteristics, but not with respect to preexisting alcohol or other drug prevention activities. There are some strong similarities across the three communities with respect to substance abuse prevention activities and emphases, but there are also important differences. To some degree, the similarities are due to statewide initiatives. The Bramley bill, described above, was responsible for the creation of task forces statewide and has helped create a broader awareness of prevention needs; however, the local task forces largely operate independently. There are still substantial differences across communities with regard to the degree of community involvement in prevention planning and in the programs that are conducted. To some degree the differences across communities reflect local strengths and needs, but it still appears that the original impetus and coordination from SAIVE may have resulted in residual effects that continue to produce benefits.

Server Training

Woonsocket—As described above, and as confirmed by server interview data, a very high percentage of Woonsocket servers have received training, with partial task force funding for the cost of training new servers. We interviewed a sample of current Woonsocket servers to ascertain the extent to which they retained the content of the training done during and after the intervention. Pre- and posttest surveys had shown significant improvements in server knowledge from the initial training (Campbell et al. 1991). Key results are shown in figure 1. Patterns of change are shown for four behavior subscales and an overall score. All show some improvement from just before to somewhat after training (pre to post), but most also show some deterioration over the 2 years since the posttesting. However, server behavior did not return to pretraining levels. These results are described in more detail elsewhere (Campbell et al. 1991).

Newport—At least in part because of the example set by SAIVE in Woonsocket, other communities throughout the State initiated server training; in many cases, the training personnel are those who learned their trade in SAIVE. For the most part, communities pay for server training with State funds (Bramley bill funds). In Newport there has been some server training, but its impact is

Figure 1. Server Behavior Before, During, and After Intervention



limited by the fact that there are many temporary servers in this resort community, especially during the summer. Some licensed establishments only operate during the summer. Public funding for training has been limited; the local task force has given it a lower priority than in Woonsocket.

Westerly—No training is done locally, although some servers have attended training in Connecticut. There has not been any public funding for training. *Westerly* is also a resort community, so it faces the additional problem of many temporary servers being hired during the summer.

Law Enforcement

Woonsocket—DWI enforcement is not as high a priority for the department as it was during the intervention period. Liquor law enforcement is at a low level and seems to have the lowest priority. *Woonsocket* now seems to lag behind the other communities in these areas.

Newport—Enforcement of DWI laws is a priority. There are also regular patrols of bars by plainclothes police. Enforcement efforts are, however, to a significant degree targeted at areas most frequented by visitors rather than the bars used mostly by locals.

Westerly—Strong DWI and liquor law enforcement efforts are in place. A great deal of enforcement effort is targeted at tourist areas during the summer months.

Community Mobilization

Woonsocket—There is a very active task force with significant community support and much communication among key groups.

Newport—A task force has been active since 1989. The extent of community support and coordination is not clear.

Westerly—A task force has been in existence since 1989, but seems to be less active than the task forces in the other two communities. Communication or coordination among prevention groups seems to be less well developed than in the other communities. Treatment providers, who participate in the task forces in the other two communities, is not present on the Westerly task force.

Other Prevention Efforts

Woonsocket—Youth programs have been emphasized in recent years. These include student counseling and treatment referral, DARE, Red Ribbon weeks, and programs for areas of high risk.

Newport—Major activities include youth programs such as student counseling, DARE, the BABES curriculum, Red Ribbon weeks, teen employment programs, and ad hoc intervention in areas of high risk.

Westerly—Youth programs include student counseling, DARE, and Red Ribbon weeks. Referrals to treatment have declined subsequent to the development of an inschool counseling program. Advertising aimed mainly at adults has been produced.

Other Factors

It must be recognized that within each community many unique factors are at work. While it is not possible to describe all the relevant circumstances for each community, a few key factors deserve mention. In Woonsocket economic conditions are substantially worse than in the other cities. The business climate has been poor in Woonsocket for some time, but this year the failure of the region's major credit unions and other economic hardships have created a genuine economic depression. Economic deterioration has, of course, had a serious impact on the city budget. The city has also had problems within the police department. For some time, there have been factional divisions within the department. The police chief recently was suspended from duty on grounds of misconduct. The suspended police chief, however, alleges that the suspension is political, and a review committee failed to find adequate evidence to substantiate the charges against him. As of early 1992 the issue remained unresolved.

In Newport economic conditions are better but can hardly be said to be booming. Newport's economy is heavily dependent on tourism, with much

income derived from bars and restaurants. In recent times many bars have gone out of business.

Westerly also depends to a substantial degree on tourism for income, most of which is seasonal. The year-round residents form a stable, tightly knit community with less migration than the other two. There have been economic difficulties, but not on the scale of those in Woonsocket.

Discussion

It is impossible fully to untangle the impact of the experimental intervention in Woonsocket from the impact of the many other events in that community's recent history. From the perspective of the community as a whole, the hammer blows of economic disintegration and political scandal easily dwarf the SAIVE interventions in their overall effect on the city. On the other hand, it would clearly be going too far to say that SAIVE had no lasting impact. It appears that the interventions, modest though they were, left a legacy that has not been erased by the loss of a highly supportive mayor, difficulties in the police department, or severe economic hardship.

Our overall judgment is that the most important and lasting effect of the experimental intervention was on community mobilization. The task force that was created for the project brought together elements of the community that had not collaborated before, and most of these elements have continued a vigorous attack on the problems arising from substance abuse. Current task force members have expressed eagerness to participate in another experiment like SAIVE, only larger—one of their main criticisms of SAIVE was that the intervention was too modest. That our community mobilization was not entirely successful, however, can be seen from the reductions in law enforcement efforts. Partial success can be claimed for the server training component of the intervention. Despite continued training for new servers in Woonsocket, our data indicate that, by their own report, Woonsocket servers are less compliant with standards than they were shortly after the original training. While there was measurable retention of the training over a time span of 3 or more years, the drift back toward pretraining behavior has clear implications. One dose of training should not be expected to cause dramatic improvement lasting many years. Furthermore, even immediately after training the servers' behavior left a good deal to be desired. A longer term approach, in which initial training is followed by motivational or booster sessions over an extended period, might be more effective than one-shot training if only because it would help to demonstrate to the owners and servers that concern with the issue is ongoing. Studies on ways to follow up and boost initial server training are needed.

Another lesson from the Rhode Island study is that more research is needed on the problem of tailoring intervention protocols to the needs and strengths of individual communities. The three communities, even though they were matched on major characteristics as much as possible, are still quite distinct. Although

all are trying to deal with alcohol problems, each faces unique challenges and barriers to effective prevention efforts. In some ways the choice of Woonsocket as the intervention site was fortunate because of the relatively lower turnover of the server population in that city compared with the others, and the lack of seasonal establishments and servers. It seems likely that the long-term impact of the server training might have been much less in the other two cities because of these factors. On the other hand, conditions for sustained police interventions might well have been better in one of the other two sites. How to match or tailor an intervention package to individual communities should be a high priority issue for research on community-level interventions.

Sustaining interventions requires a long-term strategy. We feel that community mobilization and involvement are essential because no intervention package can succeed for long without a base of local support, but these requirements alone are not sufficient. There are many economic and social pressures on bar or liquor store owners and servers to give in to patrons who should not be served, and endless competing demands for police services. Simple forgetting, especially of procedures that are not used often, can have a major impact. Personnel turnover is a chronic problem, especially among servers who often see any given job as short term. Erosion of morale should be expected, because those individuals whose actions can do the most to prevent injury or death rarely see any concrete evidence that their actions have in fact done any good. Obviously, a shortage of resources also creates important limitations, but the mere presence of extra resources does not guarantee their effective use.

Maintaining a set of interventions in a community over an extended period remains a major challenge for prevention research. Nonetheless, planned, long-term intervention strategies hold much promise. Fads come and go with great regularity, and programs to prevent alcohol-related problems can easily be dismissed by the community as just another such fad promoted by outsiders who will leave the community once their short-term task is done. A steady, long-term investment in our communities may be an important part of the price of serious change.

Acknowledgment

The intervention and early evaluation phase of this project was supported by CDC-NIAAA Cooperative Agreement No. U50/CU100832. Subsequent outcome evaluation has been supported by NIAAA R01 AA08277, William Waters, Ph.D., principal investigator.

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Training as a Strategy for Enhancing Community Action Projects for the Prevention of Alcohol and Other Drug Abuse: The Experience of OSAP's Community Partnership Training (OCPT) Program

Joseph Motter, Carolyn Rutsch, and Susan Hailman

Background of the Problem

The problem of alcohol and other drug abuse (AODA) is complex, pervading all social strata and affecting organizational and institutional life in virtually all communities. School failure, teen pregnancy, child abuse, drinking and driving, gang involvement, and neighborhood crime and violence are often intricately tied both to AODA and to one another; all frequently involve the same individuals. Despite the close connection between these problems, most efforts to address AODA prevention efforts have suffered from fragmentation, inconsistent or conflicting strategies, narrowness of focus, unclear intended outcomes, and lack of grounding in the research and experience of health promotion generally and AODA prevention specifically. The question, then, is how to pull these divided efforts together into one community prevention approach.

The research on community prevention suggests that when all segments of the community become involved and organizations begin to collaborate, significant prevention efforts can be mounted with beneficial effects on AODA and related problems for the entire community.¹ The conditions identified as necessary for such effective AODA prevention include (1) a clear and shared vision, (2) a systemwide planning process with community involvement and ownership in defining the problems to be addressed and the strategies to be used, (3) a mutually supportive and coordinated set of prevention strategies, and (4) an effective way to monitor the plans and make adjustments to them over time. Coalitions have been identified as an effective approach for shifting the focus from *activities* to a systematic, thoughtful planning process that includes the entire community.² Therefore, the literature suggests and the Office for Substance Abuse Prevention (OSAP) supports local community coalitions, involving multiple key segments of the community in collaborative, sustained prevention planning and development.

The OSAP Partnership Demonstration Grant Program

OSAP established the Community Partnership Demonstration Grant Program in 1990 with a view toward reducing illicit drug use and alcohol abuse in communities throughout the United States by building local coalitions of

multiple agencies and organizations and hard-to-reach, high-risk populations and community groups. The intent is for the partnerships to involve their communities in planning and developing comprehensive, long-term strategies for prevention of AODA so that the success of different community prevention approaches can be evaluated. According to the grant announcement, the goal of the Community Partnership Grant Program is to achieve measurable and sustained reductions in the United States in four areas: (1) alcohol and other drug use among children and adolescents, (2) the consequences of AODA (e.g., deaths and injuries), (3) drug-related crime, and (4) workplace-related drug abuse.

Instrumental to reaching this goal, the Community Partnerships are expected to accomplish the following:

- Encourage community leaders, diverse organizations, and/or interest groups in local communities to coordinate primary prevention programs more effectively and to develop new drug prevention initiatives.
- Demonstrate that the development of broad-based support within the community and close coordination with appropriate State agencies can substantially contribute to the elimination of AODA.
- Encourage and stimulate self-sustaining, multifaceted prevention and early intervention programs targeted at affected youth.

Nationally, the expectation is that the partnerships will develop and build the capacities of their communities and empower the communities to mount effective, comprehensive, community AODA prevention plans and programs.³

OSAP's Community Partnership Training Program

The OSAP Community Partnership Training (OCPT) Program was established to provide training and organizational development assistance to OSAP partnership grantees and similar coalitions. The training and development activities are intended to facilitate and support the goal of empowering communities for effective AODA prevention. The goal of the partnership training, then, is to assist and support partnerships and coalitions in developing and nurturing effective organizations. This strategy involves ensuring that partnership memberships reflect the diverse cultures and sectors of the community and that partnerships gain the knowledge, abilities, skill, and motivation to devise and coordinate comprehensive AODA prevention strategies both in and with their communities. These prevention strategies are to be targeted to specific, local AODA problems identified and validated by the entire community; are to take place on multiple fronts; and are to involve multiple sectors of the community simultaneously.

Following a model similar to that of the partnerships themselves, Community Partnership training and development is targeted to specific areas of

partnership capacity building and empowerment that have been validated by partnerships and coalitions and in which partnerships and coalitions have a vested interest and sense of "ownership." And OCPT involves multiple training and development strategies with numerous partnerships all during the same timeframe.

OCPT has developed a comprehensive set of training and development programs to meet these overall objectives. These include several institutes and a number of elective workshops:

- *Community Partnership Institute (CPI)*—The CPI is called "basic" for two reasons: it is intended to address fundamental issues facing new partnerships and grantees participate in it within 6 to 8 months of funding. It is designed to provide new ways of looking at collaboration and involvement that both model and present comprehensive and systematic planning approaches to AODA prevention.

- *Advanced Institute* —The Advanced Institute is delivered to partnership grantees as they move beyond the start-up stage, past the early organizing and planning work, and become more or less "institutionalized."

- *Cultural Institutes*—These are intended to facilitate the work of diverse cultural groups in mounting effective, comprehensive AODA prevention both within their own groups and with one another. Cultural institutes include (1) multicultural leadership, (2) African American, (3) Asian/Pacific Islander, (4) Hispanic American, and (5) Native American.

- *Community Training Workshops*—These are shorter 1- and 2-day sessions designed to address a variety of specific skills related to the work of the partnerships.

The OCPT Community Partnership Institute

For most partnerships, the 5-day CPI represents the first training activity that the group undertakes as a whole. Although some OSAP grantees existed as collaborations or coalitions prior to OSAP funding, the Community Partnership process represents a new venture for most. Therefore, the overall intent of the CPI is to initiate or support a process of capacity building and empowerment in an ascending and widening spiral at three levels: team, partnership, and community.

The first level, the team, is the intended audience for the CPI; this is a group of 8 to 12 members and key staff (or an entire small partnership) sent by the partnership to participate in the training. The next level of involvement is the formal partnership itself, which is often significantly larger in size. The highest level is the community in which the partnership is embedded. The goals of the CPI are directly targeted to the first level, but are expected to indirectly affect the other two levels. Groups attending the CPI are expected to become functioning

teams, who by the end of the training will have developed a preliminary action plan and a reentry plan to guide the processes of empowerment and capacity building with their larger partnerships back home. Over the 5 years of the grants, the partnerships are expected to take the empowering process to the next level, the community.

The goals of the 5-day CPI, then, fall into four categories:

- *Team building*—Developing the ability to function effectively as a team, including how to identify and solve problems, how to create and agree on a joint plan of action for posttraining work, how to involve others actively and constructively, and how to expand the team.
- *Prevention planning*—Acquiring knowledge and some skill in prevention planning, including how evaluation relates to prevention goals, what the literature says about what works, and awareness of the importance of cultural diversity to effective prevention.
- *Partnership development*—Building the capacity of the partnership to address its organizational problems and needs effectively; assisting the partnership as it expands to include people from diverse cultures as active participants in planning and decisionmaking.
- *Community development*—Involving the community (including all racial, ethnic, and cultural groups and organizations) in the identification and setting of community AODA priorities through the development and enactment of the prevention strategies chosen by the community.

Measuring the Impact of the First Year of the OCPT Program Training

Evaluation Goals for OCPT

The evaluation of the OCPT has two major goals: (1) to collect and analyze evaluative data and information from training participants in order to allow OSAP to identify training courses that meet community partnerships' needs, and (2) to determine the effectiveness of the training intervention in encouraging the development of the individual community partnerships, with particular emphasis on team building and prevention services planning. During the first year of OCPT, the evaluation focused primarily on the first goal, because the training curriculum was being piloted, and less on the second, because both the Community Partnership Program and OCPT were to be evaluated by external consultants. From the start, however, preparations were made to collect outcome data on CPI training participants at a point 6 months after the 5-day training. It was expected that at some point these data would be collected in more detail by the outside evaluator, contracted separately by OSAP.

Evaluation Measures

The OCPT evaluation has relied predominantly on process measures. For most training, this phase involves posttest surveys to assess participant demographics and participant satisfaction with the training. To begin to address the second goal—the impact of the training on the partnership—some outcome evaluation measures were developed. The CPI was chosen out of the four different types of training offered as the target of the more comprehensive evaluation effort. This decision was made for several reasons: it is generally the first OSAP training that the partnerships receive, all partnerships send a core group of between 5 and 12 representatives, and it conveys key points about partnership development and AODA prevention planning, activities that involve all partnerships at some point soon after receipt of their OSAP grant. In practice, the participants are surveyed three times on a 14-point Likert scale measuring participant attitudes toward the partnership as a whole (see exhibit 1).⁴ The scale is administered at the start of the CPI training, at the end of the training, and 6 months following the training. At the 6-month point, in addition to being surveyed on the cohesion scale, CPI participants, community partnership project directors, and active members are questioned regarding the dissemination of training information and tools in the aftermath of the training.

The Results: Participant Demographics, Participant Satisfaction, and Evidence of Impact on Partnership Development for the CPI

The demographics of participants trained are useful both for accountability purposes and for ongoing feedback for training curriculum development. Some key participant information is as follows:

- In the first year of OCPT, more than 1,000 community members were trained in 13 separate CPIs.
- During the first year, two-thirds of the participants were women; one-third, men.
- About an equal percentage (8 to 9 percent) of participants were below age 25 or above 55. The largest group (38 percent) was between the ages of 36 and 45.
- Educational levels of participants were diverse but generally high: 9 percent were high school graduates or less, 51 percent completed college or some college, and 35 percent had either a master's or higher level degree.
- The racial and ethnic composition of the participants was 55 percent European American, 25 percent African American, 9 percent Hispanic American, 3 percent Native American, and 1 percent Asian/Pacific Islander.⁵

EXHIBIT 1. Group Cohesion Scale⁶

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
1. The atmosphere in the group tends to be informal, comfortable, and relaxed.					
2. Virtually everybody participates in group discussions.					
3. In this partnership, conflict between member organizations gets in the way of getting the job done.					
4. There is disagreement but it is worked through to consensus.					
5. Group members fail to listen to one another.					
6. Achieving our partnership goal is a higher priority than any single organizational or individual objective.					
7. People are inhibited about expressing their feelings and ideas.					
8. Our partnership shares a common set of guiding values.					
9. There are "hidden agendas" at group meetings.					
10. The tasks or objectives of the group were well understood and accepted by the members.					
11. Leadership in the group shifts as needed to use individual talents.					
12. There is a lot of struggle for power and control in group meetings.					
13. Cultural diversity needs more attention in our partnership.					
14. I feel I am really a part of this group.					

- Finally, participants represent a diverse group of organizations including community services (22 percent), State and local government (13 percent), education (12 percent), and direct AODA services (8 percent).

Measures of participant satisfaction with the CPI and other OCPT immediately following the events are very high. More than three-quarters (77 percent) of the participants rated the event as "very valuable" and trainers as a group received an average rating in the 85th percentile. Pre- and posttraining results from the CPIs indicate an increase in communication methods and frequency; a better understanding of the partnership's vision, mission, and objectives; and a transition from an individual member perspective of "I" to a group-oriented "we." Responses to open-ended questions and anecdotal comments also demonstrate an increased willingness toward inclusion in leadership and decisionmaking. Finally, between the start of the training and the end of the fifth day, CPI participants register a significant change on the 14-point partnership cohesion scale. On a scale from 0 to 70, partnership cohesion scores increased an average of 5 points (7 percent), with individual partnership scores ranging from an increase of 19 points to a decrease of 7 points.⁸

The longer term impact of the Community Partnership training on partnership development is less well established. Six months after training, the partnership cohesion gains stemming from the 5-day CPI had fallen off. Most partnerships' scores returned to just a few points above their pretraining scores. Other indicators signal a longer term impact of the training, however. CPI attendees, partnership project directors, and active members of the partnership report that many of the training tools and much of the information presented were subsequently shared with a wider group of partnership members. More than half of all respondents reported that their partnerships received a presentation or report from the training attendees on the training; nearly two-thirds shared the action plans developed at the training with the larger partnership; two-thirds reported conducting an assessment of community risk and protective factors based on information presented at the CPI.

Comments from Community Partnership project directors demonstrate the difficulty of measuring the direct effect of the training on either CPI attendees or the larger partnership over time. They report that their partnership development is influenced by a wide range of outside factors including membership and leadership instability, community politics, staffing, and agency/organizational turf battles. The impact of the training can also be affected by whether or not the partnership sent the "correct" members to the training. Very few of these factors can be controlled by the trainers. On the other hand, project directors report that as a result of the CPI training their partnerships developed a greater sensitivity to cultural diversity issues among their memberships and in their communities. As a result, many Community Partnerships consciously increased their efforts to recruit new members to their partnerships, and, in some cases, hired more representative project staff.

As the training continues through the 4 years of the OCPT, there will be further opportunities to measure both the immediate and longer term impact of OCPT on the participant team, the partnership, and the community levels. At this preliminary point, evaluation has proven helpful for adapting the training to better meet partnership needs, and it has offered some evidence, through qualitative and quantitative measures, that the training has impacted partnership development on both the team and the partnership levels.

Notes

1. See, for example, the following: B. Bernard, Characteristics of effective prevention programs. *Prevention Forum* 6(4):3-8 June 1986; B. Bernard, An overview of community-based prevention. OSAP Prevention Monograph No. 3. *Prevention Research Findings:1988*. DHHS Pub. No. (ADM)89-1615, Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1990, pp. 126-47; D.M. Chavis and P. Florin, Community development, community participation, and substance abuse prevention. In: *Part II—Community Participation and Substance Abuse Prevention: Rationale, Concepts, and Mechanisms*. San Jose, Calif.: Bureau of Drug Abuse Services, 1990; M.A. Pentz and colleagues, Issues in the development and process of community-based alcohol and drug prevention: Midwestern prevention project (MPP). In: Giesbrecht, N.; Conley, P.; Denniston, R.W.; Gliksman, L.; Holder, H.; Pederson, A.; Room, R.; and Shain, M., eds. OSAP Prevention Monograph No. 4. *Research, Action, and the Community: Experiences in the Prevention of Alcohol and Other Drug Problems*. DHHS Pub. No. (ADM)89-1651. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1990. pp. 136-43; and OSAP, A systems approach to alcohol and other drug use and implications for prevention. In: *Prevention Plus II*. DHHS Pub. No. (ADM)89-1649, 1989. pp. 17-36.

2. See, P. Florin and D.M. Chavis, Community development, community participation, and substance abuse prevention. *Part I—Community Development and Substance Abuse Prevention*. San Jose, Calif.: Bureau of Drug Abuse Services, 1990; A.J. Key, *Preventing Alcohol/Drug Problems in Inner-City Communities: A Model*. Rockville, Md.: OSAP, undated; and I.T. Saunders, The social reconnaissance method of community study. *Rural Sociology and Development* (2):235-55, 1985.

3. Empowerment is a social action process that promotes participation of people, organizations, and communities in gaining control over their lives in their community and larger society; it is not characterized as achieving power to dominate others, but rather as the power to act with others to effect change. N. Wallerstein and E. Bernstein, *Health Education Quarterly*, Winter, 1988 p. 380.

4. The Group Cohesion Scale measures an individual partnership member's perception of "belonging" to the partnership. Since a major goal of the 5-day CPI training is to encourage team building, it is expected that the Group

Cohesion Scale will register change in scores both for the individual and for the group of partnership members attending the training. The CPI training focuses on participants' current mode of conducting business and then suggests a more inclusive method of working together to do AODA prevention planning for the community. Depending on the characteristics of the partnership members attending the training, the training may lead either to increased cohesion, decreased cohesion, or no change at all.

5. Note that the remainder of participants indicated either "other" or "no response."

6. The scale has a maximum total score of 70 for the 14 items. Positive statements are scored with strongly disagree equal to 1 and strongly agree equal to 5. The negative statements are the reverse, with strongly disagree equal to 5 and strongly agree equal to 1.

7. This rating was from among three choices: "very valuable," "somewhat valuable," and "not too valuable."

8. Note that a change in either direction is considered to represent a "positive" impact of the training since the training goals include team building as well as partnership development. The latter may involve significant rethinking of the partnership's representation of the community, both in terms of racial and ethnic composition and of organization.

Acknowledgment

The authors wish to acknowledge the assistance of OCPT staff John Peters and James Hickman in the development of this paper.

Symposium Plenary Discussion

Opening the discussion period, Jan Howard asked Robert Stout how he might do the Rhode Island experiment differently in the light of his experience. First, Stout said, his group should not have expected one session of training to convert very many alcohol servers to "the true religion of responsible beverage service." He would try to develop components to go back to that group for further training. Regarding the problem of continuing police intervention, he said, "It's easy to say the community wasn't ready for it, but I think we need to find a better way to really convince them that their own resources would be well spent in trying to prevent alcohol problems. We didn't succeed in doing that."

Ron Douglas wondered if any policies had been put in place to reinforce the server training. This action was done, Stout said. Part of the protocol was to

get establishment owners to sign a service policy before the training was carried out. Although this aspect did reinforce the training, it did not make it permanently effective.

Sandra Putnam said she would not say that the Rhode Island project "failed." It may well have reduced the injury rate, at least during the first year. Also, one of the chief problems with the police was their lack of resources. The police were depending on money from the prevention grant to support their activities and did not get money from the city council to continue those activities. The police also were concerned about issues of legal liability. For instance, passive alcohol sensors were provided to the police department but were never used because of fear of lawsuits. "There were all sorts of barriers within the police department to implementation of the strategies," she said. Diane McKenzie observed that Stout seemed to be saying the project had no effect while Putnam was saying that it did have an effect. In clarification, Stout said he was focusing on maintenance of the effects. "I think we definitely had effects, but the focus of this talk was on what was sustained and what wasn't."

Robin Room asked for clarification of the method used to evaluate the training described in Motter's report. Motter said some of the key issues being addressed were the sense of inclusion, the sense of clarity around roles and responsibilities within the partnership, the lines of communication in the planning effort, and the sense of clarity about the decisionmaking process. Some people get a sense of exclusion because they do not understand how decisions are being made, he said.

Issues of Transfer and Ownership: Commentary and Reflections on the Day

Sally Casswell

Talking of issues of transfer and ownership immediately emphasizes the perennial dichotomy between the research position (and the position of the research funding agencies) and that of the community. I want to start by making a couple of comments about the concept of community and the concept of research to set the context.

Jussi Simpura asked us a very interesting, as well as funny, question: What is *not* community action? This question pointed out very clearly how difficult it is to give an exclusive definition of community. I think what has been emerging at this meeting is a cultural difference to some extent: At one extreme of the continuum is the notion of grassroots, the ordinary folk, and, at the other end, professionals and bureaucrats. Especially in North America there seems to be an allegiance toward the grassroots end of the continuum. I think we have learned during this meeting that the emphasis on grassroots is not so much a feature of Britain, Canada, Australia, and New Zealand, and I expect as we see the development of community action in Scandinavia we are going to see much closer parallels with Canada, Australia, and New Zealand. Perhaps because of a greater tolerance of the role of the State in one's life, the definition of community is more likely to acknowledge the role of the professionals and bureaucrats. I will come back to the definition of community a little later because of its relevance to this topic.

But first a couple of words about research, and again I am going to use the extremes, to make it very clear. At one end of the continuum is research as one of many tools that can assist in the development of community action. At the other end, the primary goal seems to be to demonstrate methodological expertise (often in quite small subsets of the methodologies available to social scientists) or to explore theoretical issues using community action as a tool. I am not for a moment suggesting that any of the papers we have heard at this meeting fall at that extreme end of that continuum, but I think we are aware that there *is* a continuum and the projects we have heard about are at different points on that continuum. There are differences in degree, and this is likely to affect the issue of transfer and ownership of community action projects.

Another comment is on the kind of language we use. We talk about projects and programs. Projects and programs imply start points and end points. Of course, this makes sense when we are talking about situations in which external funding is coming into a local community. But we should not allow this kind of language to blind us to the fact that the policy negotiation process is ongoing. As Christine Lubinski, a U.S. public health advocate, said recently

at the Kettil Bruun Society meeting in Perth: Policy goes on with or without researchers. Perhaps it is important for us to remind ourselves of that from time to time. There is no blank slate, but instead a dynamic mosaic of policy that is shaped by alcohol and other drug problems in a community; perhaps, therefore, the community action programs most likely to be effective and sustainable are those that build on that mosaic.

A word now about the concept of evaluation. The question has arisen throughout our discussions—and I think it is a relevant one for issues of transfer and ownership—of the way our finite financial resources are distributed in the evaluation area. Outcome or summative evaluation again implies an end point—that there is a point in time at which the project is ended and is judged worthwhile or not. Now, outcome evaluation definitely makes a huge contribution to our understanding of what strategies are effective and what works. My comments are not meant to belittle this process in any way, but perhaps all of you would agree that this end of the evaluation continuum should not take all of the resources. Current practice often assigns the bulk of evaluation resources to outcome evaluation at the expense of process and more particularly formative evaluation. Process and formative evaluation are more congruent with the ongoing nature of the policy process and community action. Formative evaluation is an interactive and dynamic process. It is not the same as process evaluation, which is the formal activity of documenting the process of a project and then expecting, in a rather distant and detached way, that the written report of that will be fed into the development of the program. It is a much more dynamic and interactive process that implies partnership between researchers and the community, and implies in fact a considerable amount of ownership by the community as the project and its activities are developed.

The next question I want to raise is what evaluation indicators are relevant. I think different sectors of the community will be interested in different questions, different outcome measures, and different outcome indicators. Sometimes we may lose sight of that. It is not always, for example, the "big ones," such as whether injuries in traffic crashes have been reduced, that influence whether or not a community adopts a program. We have an example of that in the Woonsocket experience. Although the injury rate went down, the project as it existed was not adopted by the community in that the level of police activity was not maintained. Outcome evaluation may be very influential in the adoption of a program by a community, especially if the information comes out quickly enough and is disseminated adequately, and if there are no significant obstacles in adoption of the strategy, either in terms of implementation costs or prevailing policy trends.

However, measurement of other, more intermediate indicators often collected as part of a process evaluation may be influential in whether or not the community picks up particular strategies and carries them on under its own resources. A demonstration that strategies were feasible within the community

and that they were acceptable to key players within the community may be essential. Furthermore, the very process of documenting what has happened seems to legitimize the overall activity and make it more likely that it will be picked up. This was our experience in New Zealand in a community action project where the expansion of community workers throughout New Zealand took place in advance of the outcome evaluation's results becoming available. Fortunately, the results were positive; I do not know whether it would have made a great deal of difference if they had not been positive.

Another important issue is that the kind of strategies the project is promoting may affect whether they will be owned by the community and carried on long term. Those strategies that involve a change in the environment very often have costs for the public sector—for example, having to enforce the law. Other environmental strategies have costs for very powerful vested interests, as when you take up the issues of availability and promotion of alcohol. Those strategies are not on a level playing field in terms of whether they will be picked up and adopted by the community, compared, for example, with educational strategies that are innocuous and ineffective and therefore do not step on anyone's toes. As we saw in the Woonsocket case study, the coordination is still there, the activity is still there, but the direction and the strategies have changed. If the strategies are contentious, they need support from some influential sectors of the community and the "what's in it for me" factor comes to the fore. That brings me back to the definition of community. Which sectors of the community are we talking about when we ask who is going to own the project, to whom is it going to be transferred to take it on long term? This point is where the issue of grassroots versus bureaucratic and professional sectors becomes very important. Bertil Hanson's process evaluation told us, not surprisingly, that participation in their community action project was more likely among the individuals and groups who benefited most.

I think our recent history shows that some community sectors are likely to initiate and sustain strategies without researchers' contributions. These sectors include groups like Mothers Against Drunk Driving whose members have very strong personal experiences that leave a residue of emotion about the issue, people like the residents close to alcohol outlets, or, as Dr. Sharma's paper illustrated, residents next to illicit drug suppliers; members of the helping professions who pick up the pieces; retailers, particularly in North America where they are afraid of litigation; professionals involved in maintaining public order; people involved in the licensing process; parents; and even elected officials to the extent that there is news in it and it is good news and will lead to electoral support. It does not seem so likely that the grassroots, the so-called ordinary folk, are sitting around with nothing to do, waiting for an issue to come up. Those people can be mobilized to a certain extent, they will sign petitions, they will join in a campaign, but they are not likely to drop the rest of their lives to put very large amounts of time and effort into developing strategies that are quite difficult to put in place and maintain.

The papers presented today were extremely interesting to me. I received a much greater understanding of the complexity of the U.S. situation—just to hear of the number of organizations involved in the OSAP project, the way in which projects are compartmentalized into so many different areas, and the difficulties that that must bring to both evaluation and development of the project. The Woonsocket project sounded as if it encountered a lot of complications and difficulties, although most communities in most parts of the world have some of that. What I did not get from the presentations was an understanding, particularly in the OSAP situation, of what the strategies are going to be—what sectors of the community are going to be involved in these projects. I think I understand why: I think it is part of this overall ideology that these things should arise spontaneously from the grassroots. The training program in the OSAP project is a good attempt to transfer technology and research skills to the communities, to try to get a better definition and a greater likelihood of effective strategies being adopted by the community. But I suspect it would need an ongoing process of interaction between people with research-based knowledge and the community players before we could hope to see some of the more contentious and more effective strategies taken up and adopted. I wonder which sectors of the community are likely to gain something out of the adoption of those strategies and therefore are likely to continue with the project in the long term?

Woonsocket is an interesting case study in terms of long-term sustainability. We have a situation in which coordination and communication are maintained. Resources are still going into server intervention but nothing additional into police activity. I think this fact demonstrates the importance of the political and economic context of these programs. What I would like to know is, here where you have very powerful outcome evaluation results, have those results been made known to the community? Would a different dissemination of the results have made any difference to the likelihood of greater enforcement activity? What was the relationship between what happened in Woonsocket and the Bramley bill? Was there any way in which the activity stimulated the passage of that bill?

To ensure ownership of programs and their sustainability there seems to be a need for structural change, and we need to think in terms of how effective strategies can be made to benefit certain sectors of the community so it is more likely that the strategies will continue. In the case of Woonsocket where police equipment was bought by the research project but not used, I think this example shows how an interactive discussion process with much more sense of partnership could ensure that resources would be better spent.

In summary, I have tried to draw attention to the importance of the kind of research project in giving preeminence or nonpreeminence to research or to the program. As for the evaluation process, and the need to include an interactive formative approach to evaluation, we need to think about the evaluation

indicators in terms of what impact they will have on the transferability and long-term sustainability of the project and the importance of linking strategies with particular sectors of the community for which there are rewards.

Tensions in Community Action Research: Reflections on the Conference

Michael Hilton

As I have read the papers and listened to the various presentations, I have had a recurring sense of the tension at work in much of the conceptual material that was presented in this conference. Unbeknownst to me when I prepared the outline of my remarks, Norman Giesbrecht chose to speak to this same issue in his opening remarks at the beginning of the conference. I want to return to that theme again: the tensions that are at work in this field.

I think this sense of tension has many aspects or facets or axes to it. If I had to summarize it in a single phrase, I think the aspect that best describes it is the tension between practitioners and researchers. But I do not think it's limited to this one aspect. There is also tension over goals, over procedures, even over the fundamental assumptions that we bring to our work.

This feeling just jumped out at me right from the beginning of the set of papers when I read Louis Gliksman's piece. That paper contained a litany of practical barriers to getting a traditional research project done: budget restrictions that precluded the use of any control group; scheduling constraints that prevented the needs assessment from being done before the program planning was supposed to be done; personality conflicts, a dispute over whether a certain person was allowed to sit in on the interview training sessions and how that disrupted the whole training session; in another case, mutual charges of sexual harassment were filed by a program coordinator and a secretary. This is some of the stuff of the day-to-day life of working out there in the community. All of it has to be profoundly frustrating to anyone trying to conduct a solid scientific study.

One wonders how it is possible to do any research under such conditions, and it is a tribute to Dr. Gliksman and his previous record that I think we can expect a good paper to emerge from this study. The kinds of problems he mentions so frankly are not unique to his project, however. I saw them peeping out from several of the other papers and discussions as well. Dr. Weiss discussed survey results from Israel, which were decried by the Kibbutz community leaders as the unreliable findings of an outsider. Tim Stockwell described a lack of interest in enforcing the laws on serving intoxicated patrons by the appropriate alcohol control authorities. Jacek Moskalewicz talked about the complete disruption of prevention programming by the historic transformations of Polish politics. We heard from Robert Stout in a less dramatic way about the problems posed by various people in the government with whom the researchers were trying to work and of the general economic conditions that impacted so negatively on the potential for achieving some server intervention—again, due to forces beyond the control of the investigators.

I think all these examples illustrate how research can be profoundly undermined by some of the realities of working in the communities that we wish to study. For me it was Alex Wagenaar's paper that did the best job of trying to sort out and describe some of the dimensions of these underlying tensions—they call them tradeoffs in that paper. There was the tradeoff between objective research and community action, which in my view raises the most fundamental issue that we should leave here thinking about. How far away from the traditional standards of value-free, objective research are people willing to go in order to pursue community interventions that inherently require a degree of commitment and real drive for the cause of community change?

A second dimension they identified was the power of the research design versus the power of the intervention. Of course they are not talking about statistical power here but about ownership and control. This is really the core of the matter. Who decides what the intervention is to be? Who controls its development? Who owns not the problem but the potential solution to a problem? I really appreciate Sally Caswell's summary for raising these kinds of issues.

To continue recapitulating some of Alex's points, the issue of easy versus difficult interventions is again an important tension in this field. I thought the individual versus community consent issue was very important. Most of the consent guidelines and procedures that we have were developed for individuals, specifically within a context of clinical research. I do not think that we have well-thought-out codes of ethics and human subjects procedures for studies in which we treat an entire community as the experimental unit, and I would like to see us do some more work in thinking through these issues.

Other issues that Dr. Wagenaar raised were empowerment versus control, which again raises the fundamental issue of who is in charge and in control. Also, he mentions the conflict versus cooperation issue. Should an intervention pursue a cooperative, accommodative line of thinking or should it confront the vested interests that exist? In short, I found Dr. Wagenaar's paper to be an excellent summary but I think I can expand on it by adding some ideas that came out of the other papers, and thereby show some additional dimensions of the tension within this field.

First of all, there is the quest for knowledge in particular and the quest for knowledge in general. Many of the papers dealt with a particular intervention, and I was left with the question of how does this affect the world more generally? For example, look at the Lysol abuse paper by Hewitt and Vinje and Barbara Ryan's excellent spring break study. Tension exists within these papers between trying to understand particular events and trying to understand general cases.

I would also mention the insider/outsider distinction that Shoshana Weiss touched on. A question we do not often ask in this regard is how does the outsider open up to the community needs and accept the perceptions of the community? Something that Kathy Stewart pointed out in her paper was that it is generally taken as an article of faith that comprehensive, communitywide solutions are needed, but the paper raised the question of how realistic this expectation is. It rarely happens that we have the kind of comprehensive, broad, multifaceted communitywide intervention strategies that people say are needed, which raises the further question of how do we know they are necessary if they are so rare and have not been studied very much.

Finally there is the tension between researchers and policymakers, which I believe came out of the oral discussions during the conference more than from any particular paper. This issue, of course, is something I have been more intimately familiar with over the last year since I have taken a job in government. To me the element of timing in this relationship is the key, but it is a very troublesome thing to deal with. It seems to take far too long after we have identified an idea that we think ought to be researched for us to issue an announcement and get research on that idea funded. Similarly, it seems that far too much time passes between the time that a study is funded and the time that results are available to the public. Those things frustrate the coordination between policymakers and researchers.

What do we make of this menu of tensions? When I first wrote my talk, the first answer that came to me was that we should adopt some sort of marginalist, conciliatory strategy in which we try to resolve apparent tensions and reduce conflicts and differences between researchers and the people they interact with. But I think it is too facile to expect that we will be able to do this any time soon. So I do not offer such marginalist solutions and I do not propose any formula that would help us resolve these multifaceted tensions. Instead, I am convinced that the tensions I have described will be with us for some time in the future. Therefore I would like to close by outlining some of the characteristics that the community intervention research field will most likely have, given that it is characterized by profound tensions on a number of important dimensions.

First of all, I think we have to expect that there will be a wide diversity of approaches that characterize the field. Different people will stand at different places along the continuum on each one of the axes of tension that I have discussed. I think as we look around the room we see that our colleagues have rather different points of view on some of these fundamental issues. Second, I think there is a fundamental disagreement on some of our principal assumptions, especially the value and virtue of positivist social science. I think that this disagreement underlies much of the differences on the issues I have described. Third, and this is unfortunate, I think we should expect progress to be modest, to be somewhat slow, in a field that is confounded by so many differences and tensions. Fourth, I think there should be a search for flexibility in our research

approach. Fried Wittman mentioned that opportunism is acceptable. Other people mentioned the need to have one's eyes open for modifications in a program and to take advantage of situations that arise. This ability is especially a virtue in this field. Finally, in an attempt not to be completely pessimistic, I think we can note that tension is a source of creativity. Again, I owe this idea to Fried Wittman. I am sure that from the confused and divided state that the field seems to be in we can expect creative approaches to emerge as people struggle with these tensions and problems. I think that is going to be one of the great strengths of this field and we look forward to the creative solutions that will emerge between now and our next meeting 3 years from now.

Symposium Plenary Discussion

Norman Giesbrecht commented that the presentations reminded him of an observation Robin Room had made at the Scarborough conference on the difficulty of determining what to evaluate. "Usually the things that research grant agencies want evaluated were novel, high-profile types of interventions, while the things that were going on in the community on a routine basis, day to day and month to month, were not that sort of thing," Giesbrecht said. "I think that's an issue that is still here."

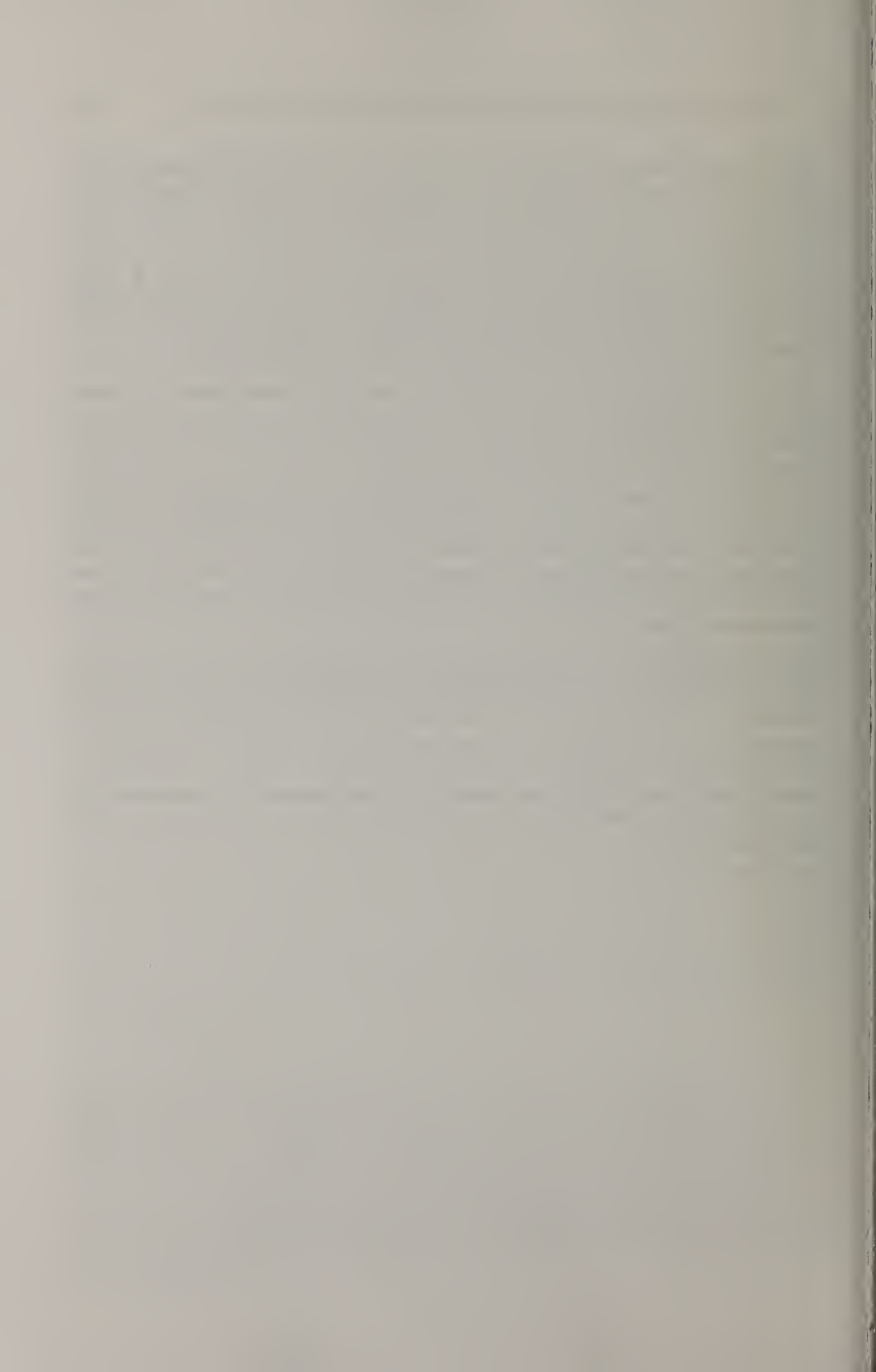
Friedner Wittman said he believed one of the difficulties with the Rhode Island project was that it was individual focused, aiming at changing police practices at the patrolman level or the practices of a server behind the bar. "It didn't do much to change policies," he said. "I think that experience ties in very closely with what Sally Casswell and Michael Hilton said. What we're all about is putting up with tensions at the local level." The researcher needs to deal with the planning tension that exists at the local level between all the competing interests in the community. "The name of the game is change....What we're really doing in community planning is laying groundwork for addressing those tensions.... The kind of effort it takes to do that is very different from the kind of demonstration research that the Federal Government in the United States is accustomed to funding."

Sandra Putnam spoke of the dilemma created by the fact that communities are not isolated and are affected by influences from outside and in turn may affect things beyond their own borders. An example of this was the server training component of the Woonsocket project. Two of the persons trained as trainers in the project went out and started their own for-profit training enterprise, which is having an impact in other parts of the State. This occurrence illustrates a potential dilution of effect not measured in the target community itself, yet it also speaks of programmatic success through diffusion of innovative training programs.

Ron Douglas, noting the attention given at the conference to research design and communication of findings, said he believed there should have been more attention given to the interventions themselves and how powerful they were. "We're left with the question of how do you get people to buy in, how do you get them to follow the example you're providing." He said he hoped a future conference would take a closer look at interventions and what appear to be the more powerful strategies emerging. "If we can be a little more precise on the intervention side, we can be more precise on the evaluation side."

Sally Casswell said she is not sure that researchers compromise their objectivity when they get too involved in the intervention. The research effort can be divided into three activities: framing of the research questions, the collection and analysis of data, and the interpretation and dissemination of results. The first and third of these activities are not value free and therefore would be open to criticism by those who disagree with the values they reflect. But researchers should try to make the collection and analysis of data an objective exercise that reflects no value judgments. One way to approach this problem is to use research teams, never using the same people to do both process evaluation and outcome evaluation.

Tom Greenfield commented that some of the problems being described in the execution of programs could be addressed by confining research to formative evaluation and not necessarily documenting the actual services delivered or ensuring that in all respects the program was carried out as planned. A problem arises in the effort to be flexible and willing to adjust. "I wonder if in some cases we aren't adjusting to the point where (the activity) might not even be recognizable and definable in terms of something that could be generalized somewhere else."



CHAPTER 7

Thematic Workshops

On the second and third days of the symposium, participants met in four workshops, each devoted to a different theme. At a plenary session on the final day of the symposium, recorders presented summaries of each workshop discussion.

In a preliminary report on the workshop on **Emerging Research Paradigms for Community Studies** Jan Howard provided background information. A reason for this workshop, she said, was the emerging interest in drawing a distinction between what is science and what is something else. This distinction has practical implications, particularly for review committees determining whether or not to fund a project.

The state of the art for community prevention research depends a great deal on the questions and the resources available, Howard said. She noted that the criteria are different for natural experiments, such as raising the legal drinking age, than for investigator-controlled experiments. Also, a related question is when do compromises (imposed by political realities, budget constraints, and so on) completely erode the credibility of the community research project. In a sense then, the group began to explore what was ideal and what was pragmatic.

Norman Giesbrecht, in the final report, said the workshop had looked at four main questions: What are the necessary research and design conditions for doing community action studies? How do we design and conduct projects so that after they are completed the results have long-term utility for making policy decisions and for use in other communities? What are the appropriate methods for conducting the project? Are these methods generic or are they linked to aspects of a particular project?

A number of necessary conditions were advanced, he said, some of them not exclusive to this type of research but relevant to other social science research as well.

First to be listed was objectivity, which included an awareness of biases as well as methods for accounting for biases, an ability to step back from the work and see the interplay of forces that contribute to the dynamics of the project. This situation does not mean the researchers are completely detached from the project, but they are able to take a reflective stance.

Another condition listed was the generalizability of the results or replicability of the project, as well as the exactness of measures and having a sufficient

number of measures. It would be difficult to interpret what was happening on the basis of single, very large aggregate measures. It was also noted that repeated measures are important, for a number of reasons. The changes in the course of a project are likely to be incremental; repeated measures allow a researcher to assess this process. "We don't really understand process," Giesbrecht said. "Evaluation has not fully been able to unravel the process, and probably never will, but repeated measures would be essential to try to get a handle on that."

Randomization and matching also were discussed, he said. The sense of the discussion was that careful matching of control and experimental communities is important, but that randomization is not necessarily required in all projects.

With regard to long-term utility, it was pointed out that people managing or facilitating projects should ask what the effects are likely to be 5 years after the project is completed, and how they will influence policymaking. In a discussion of methods and appropriate questions, one emerging point was that the method would depend on the knowledge available on the question. If there were detailed knowledge available, certain methods would be used; if a relatively new area were involved, a different methodology might be more appropriate.

Methods also might depend on target populations and political realities. "If a decision was required in a short period of time by a government or an agency, and research was being requested to facilitate that decision, this might determine the method," Giesbrecht said. Finally, the issue of how the information would be used probably would have an impact on the methodology, he said.

Howard added that in this workshop there also was discussion of whether researchers might be wearing two hats in connection with a project, and that the goal of science might conflict with the goals of an action-oriented group.

Tom Greenfield reported that the workshop on **Interactions of Research and Policy** found there is a continuum of research in relation to the policy process, which includes, on the one hand, large-scale discrete projects that inform one or more national policy debates, and, on the other hand, small-scale research efforts that lead to local political actions. There has been little policy impact analysis on this subject. The group noted that the planning process might be considered a research exercise affecting policies and other outcomes.

"We felt that the research community as a whole needs to play a larger role in shaping national and international research agendas," he said. The group also noted a need to promote the idea of prevention research as being worthy of funding, raising its credibility in the eyes of government. "We felt a need to educate both professional groups and governments about the appropriateness of distinctive methodologies...and to advocate for changes in agency priorities."

The group also discussed the role of international links and approaches, citing the Canadian support of Israeli scientists. Conferences like the present one can further that end.

The role of researcher as distinguished from research was a hot topic, Greenfield said. "We focused on the time and energy and skills required to enter the policy fray, and the problems some researchers have in translating complex findings into 'sound bites' or one-page briefings." This issue brought up the need for researchers to "extend their antennas" in order to pick up on key questions whose answers will shape the policy process. There was discussion of researchers who had been characterized as "buccaneering," who are willing to be definitive in the face of ambiguity or uncertainty, and the risks of losing objectivity and winding up without credibility. "A little defensively we wondered about successful influences—those who hit upon findings that were in support of recommendations whose time had come and in effect were going with the flow of national economies or other kinds of movements they happened to hook onto."

Cultural differences and how public policy evolves were discussed for quite some time, he continued. "Some of us saw possibilities for evolving common principles that might cut across the differences that exist between political systems, and perhaps some of us felt there was a seemingly enormous array of different country-specific systems that would affect how one acted.... This is clearly a major issue for international researchers." This issue led to a discussion of the fact that policy agendas are readily overwhelmed by big issues of the day, which tend to lower alcohol and other drug problems on the agenda. A choice may have to be made between advocacy and the passive dissemination of research findings. Finally, there was discussion of where researchers get priorities for the areas they will study and the role of alcohol industry funding in influencing those choices.

Louis Gliksman said the group discussing **Grassroots Versus Research Agendas: Conflict and Synthesis** questioned whether their workshop had an appropriate title, suggesting that a better one might be "Grassroots and Research Agendas: There Need Not Be Any Conflict." Essentially, he said, this points out that there are common agendas that exist within the context of community action research, that researchers and the community both share the view that something is a problem and that something has to be done about it. They can reach a consensus on how best to proceed. There is then an interaction between researchers as change agents and community members, moving along a continuum with points of intervention determined by the strategies.

Gliksman said there was agreement that the relationship between researchers and the community "has to be based on integrity, it has to be honest, with

open lines of communication that indicate what you can do and what you are willing to do—what you can share with the community and what the community can share with you. It has to be recognized that this is a mutually beneficial relationship. There has to be some discussion as to whether the research is a priority or if change in the community is a priority.”

There was a long discussion of the ethics involved in working with the community and individuals within the community, Gliksman continued. The discussion produced the “beginnings of a list” of ethical issues:

- Are we asking the important questions? If we aren’t, why are we doing the research?

- There must be a true consultation process. “We as researchers have to be willing to listen to the community and hear what the community is saying—to try to accommodate the needs of the community. If we can’t do this, tell them so.”

- There has to be a process of feedback. The feedback issue leads to further questions: How necessary is it to collect information from every level of a project? At what level do we decide what is important information and what is not important information?

- “We have to be honest and forthright about our own values.”

- Researchers need to address the issue of sustainability of the project after they have pulled out, and the replicability of the program itself. There was discussion of various ways researchers can help ensure the sustainability of a program. “The bottom line was that there are no guarantees that after the researchers pull out, the program can be sustained. One does what one can to ensure that at least the structure is there (so that) a minimal amount of money may be required to maintain the changes that have occurred.”

- The bottom line for the ethics of the research community may come down to “do no net harm.” The benefits that accrue to the community should outweigh any harm to the community.

“We have to think through potential issues and understand what we will do under certain circumstances.... We have to be ready to deal with them rather than deal with them on an issue-by-issue basis,” Gliksman said. The issue of race and ethnicity must be accommodated. “Various groups have to be recruited throughout the whole process rather than have a White middle-class researcher come in and dictate to the community without getting input from the people who will be affected,” he said.

He said it could be concluded from the wide-ranging discussion that there need not be any conflict if there is communication and a true consultation process between researchers and the community.

Shireen Mathrani reported that the workshop on **Strategic Choices of Goals** discussed cultural differences in how policies are evolved, with comparisons of experience in England, Canada, Finland, Norway, and Denmark. There was considerable discussion of how countries with a tradition of centralized control will respond to deregulation and the end of alcohol monopolies, such as is likely to happen in Finland when it joins the EC. Although what will happen is generally unknown, the experience in Poland reported earlier at this conference suggests that alcohol consumption is likely to increase. Further, the group concluded that the concept of community action is difficult to interpret where community organizations are mainly official ones and are identified with the State.

The discussion compared community prevention approaches in the Nordic countries with those in North America, with Britain somewhere in the middle in terms of contrasting social norms.

It emerged from the discussion that prevention programs may prove to be unpopular when they are financed with public funds and thus viewed as offshoots of the State machinery. Due to high taxes, prevention programs have a very difficult task, as in Finland where price reductions are considered a cause for celebration.

"Looking at policies across the European Community, at the top of the agenda are issues concerning agricultural and economic policies, and right at the bottom you'll find alcohol and social policy issues," Mathrani continued. There appears to be no Europe-wide alcohol policy being developed. The policies and views of EC members are very diverse and no health or social issues that are likely to threaten economic interests will be discussed in the EC forum.

The group concluded that there would be great difficulty in transferring community action strategies from North America to northern Europe. For example, the northern European countries have no concept of the legal liability of alcohol servers for injuries resulting from service to intoxicated persons. At most, such an act might be considered to be a "failure of duty," and the server may be fined. Server training, then, would have to be based on some other form of motivation than the threat of being sued. As for North American models of prevention campaigns aimed at heavy drinking by college students, these too would be difficult to transfer to northern Europe because universities there usually do not have a defined campus where interventions can be targeted.

Further, Mathrani said, the group came to the conclusion that a possible motivator for a particular community program would be evidence that it would reduce costs to the health service and allow a reduction in local taxes. However, the connection between alcohol education, costs, and taxes is difficult to prove conclusively. The group also looked at drinking and driving, and noted that the incidence of this problem is much lower in northern Europe than it is in the United States. It would appear to be easier to convince northern Europeans

of the importance of nominating a nondrinking driver and to take advantage of public transportation as an alternative to driving after drinking.

Finally, she said, the discussion turned toward the transfer of prevention strategies from Europe to North America. The opinion was expressed that if Canada or the United States were to attempt to impose laws and penalties for drinking and driving as strict as those in most northern European countries, they would be resisted on grounds of infringement on civil rights.

The group concluded that transfer or replication of programs is an important idea to explore, Mathrani said, but admittedly it would be difficult to carry out—even from one neighborhood to another and certainly from one country to another.

Ron Douglas added that another interesting idea that arose in the workshop was that science may be in trouble in terms of providing communities with solutions to their alcohol and other drug problems, even though the pressure is being placed on scientists to do just that. He said the broad conclusion was that community action for prevention as it is known in North America is not likely to happen in the Nordic countries.

The floor was then opened for comments on the workshop reports. Jan Howard recounted some of the derogatory references to prevention workers that she had heard from clinical researchers. This statement led to an account by Jeff Cameron of his experience in a prevention office within a treatment hospital: "Sometimes when we go in in the morning we feel the need to build barricades around our office. There's a sense sometimes in the treatment community that what we're doing doesn't fit well with treatment, such as using numbers to try to operationalize moderation for people, and so on." He said what his people try to do in defense is to emphasize the disparity between the health care dollars that go into treatment and the numbers of drinkers for whom treatment is appropriate, making a case for a reallocation of funds to provide more resources for prevention.

Sally Casswell said that in her workshop there was more concern about whether research was being done well enough, with a conviction that researchers need to seek greater participation from public health advocates when framing their research goals, and, further, that there is a need for more research on the policy development process and community action process. Jim Anderson spoke of the importance of the communication of research results to the lay person, in a way that it can be read and understood by political decisionmakers. He said the public seems to be aware of the negative consequences of inappropriate alcohol use, but prevention research findings are not being translated into the kind of information people can assimilate and act upon.

Eckart Köhlhorn noted that in Sweden the State has control over much of the information about alcohol sale and consumption, and over the educational

materials about alcohol in the schools. "If you were to create a project at the community level, the range in which you could do anything would be very limited," he said. But he added that there was good reason for his country to take part in conferences like this because the situation can be expected to change when Sweden joins the EC. Geoffrey Hunt noted further that there is a trend in Europe toward centralization of authority but at the same time there are trends within regions toward decentralization. He said it will be interesting to see whether the upsurge of regional or nationalist feeling leads to a community-based or regional movement against increased "homogenization" in Europe.

Howard wondered if resources would be available to study these trends in Europe. Robin Room commented that the main thing that produces funding for research in the alcohol field is a "vague societal guilt." From comments heard at the conference, he said, he would conclude that this guilt is diminishing in Scandinavia, and the decline is not being counterbalanced by a rise in Italian guilt. It might be fair to speculate, then, that resources for alcohol research in Europe will decline in coming years. Jussi Simpura said it was his guess that resources would not increase, at least for sociologically oriented research even if there were greater support for medical research. On the other hand, the move by the French Government to ban advertising of alcohol could encourage other countries to follow suit, and much may depend on what happens in this respect in Germany. Köhlhorn pointed out that Swedish officials acknowledge that a rise in alcohol problems will be a price to pay for the country's entry into the EC, and a commission already has been formed to look at the impact on the nation's health.

Turning to North America, Friedner Wittman said the United States is in a period of shrinking resources, and researchers need to be more efficient in what they do. "A lot of prevention planning at the local level is not about money but about organization—how organization occurs." The conference has given him the impression that much of the community-level prevention effort in the United States in recent years has been largely in the normative sphere, on education and persuasive approaches. "We're learning better about how to do regulatory approaches, but we're still fairly green at it." In Scandinavia, he said, the opposite may be the case, with more emphasis on regulatory measures and less on normative influences. As resources become more scarce, the result may be that localities in the United States must become better at managing regulatory resources while localities in Scandinavia must become better at managing normative resources.

Room noted that in California the State government had preempted control of the regulatory process, but that Wittman and his colleagues had found ways around this by using zoning ordinances and other powers of local government to influence the availability of alcohol. This might prove to be a pattern for the future in Europe.

Commenting on Wittman's remarks about tension between researchers and community advocates, Paul Duignan said he believed the answer lay in considering what is good science and what makes good scientists. "If a scientist is studying community action, and, as part of the process, crushes it, then he's actually not a good scientist."

Howard concluded the discussion with some observations about current NIAAA-sponsored research that is international in scope or provides a basis for comparisons between cultures and countries.

Appendix

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